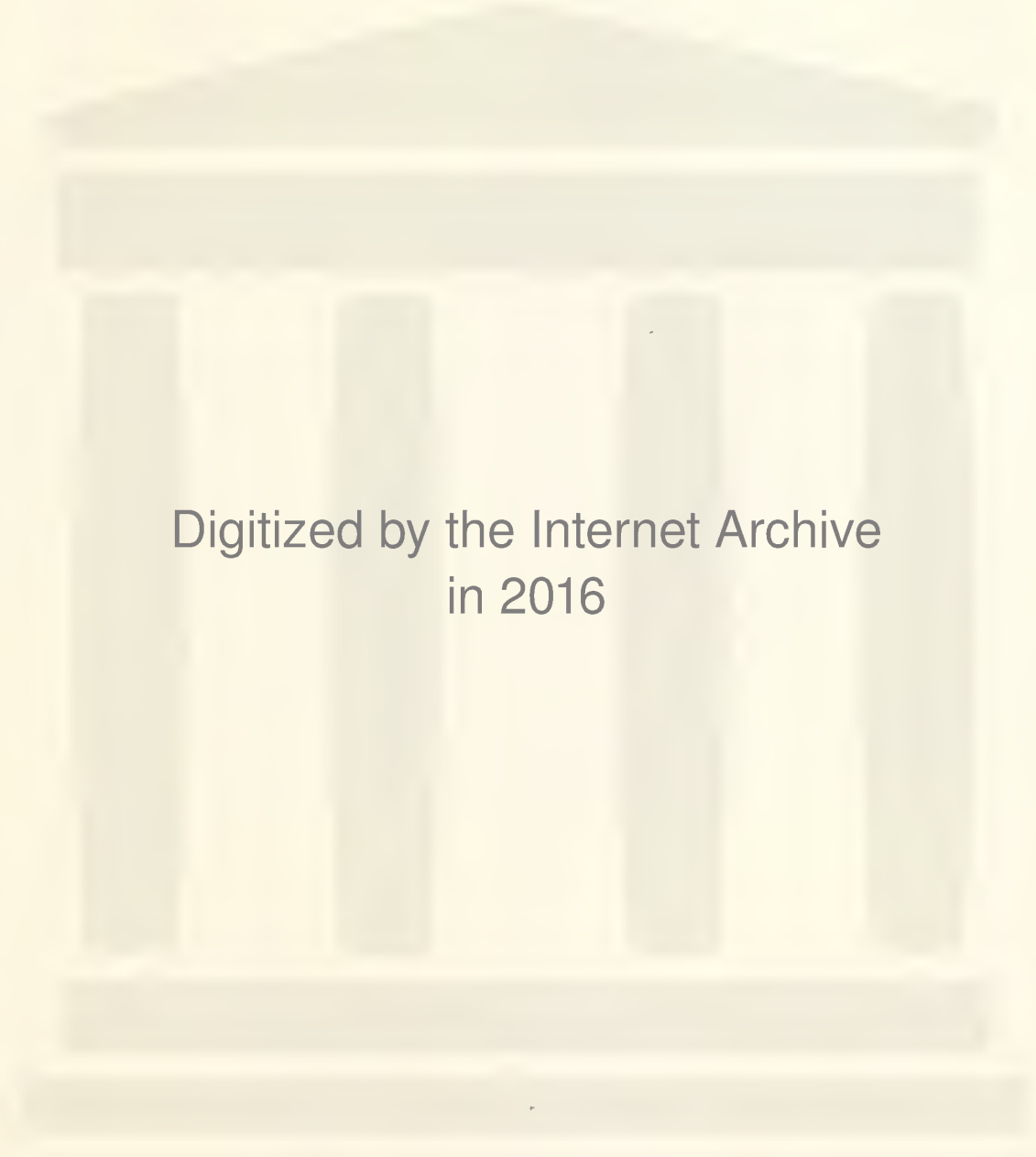

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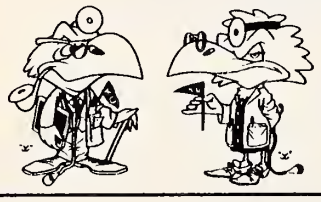
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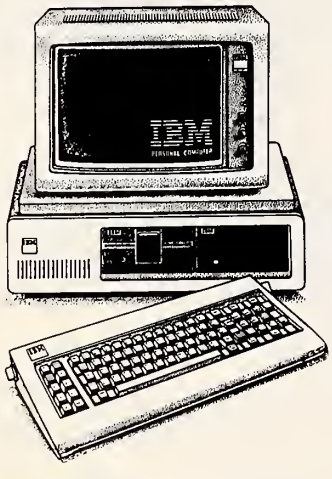
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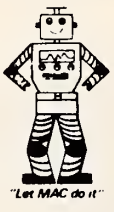
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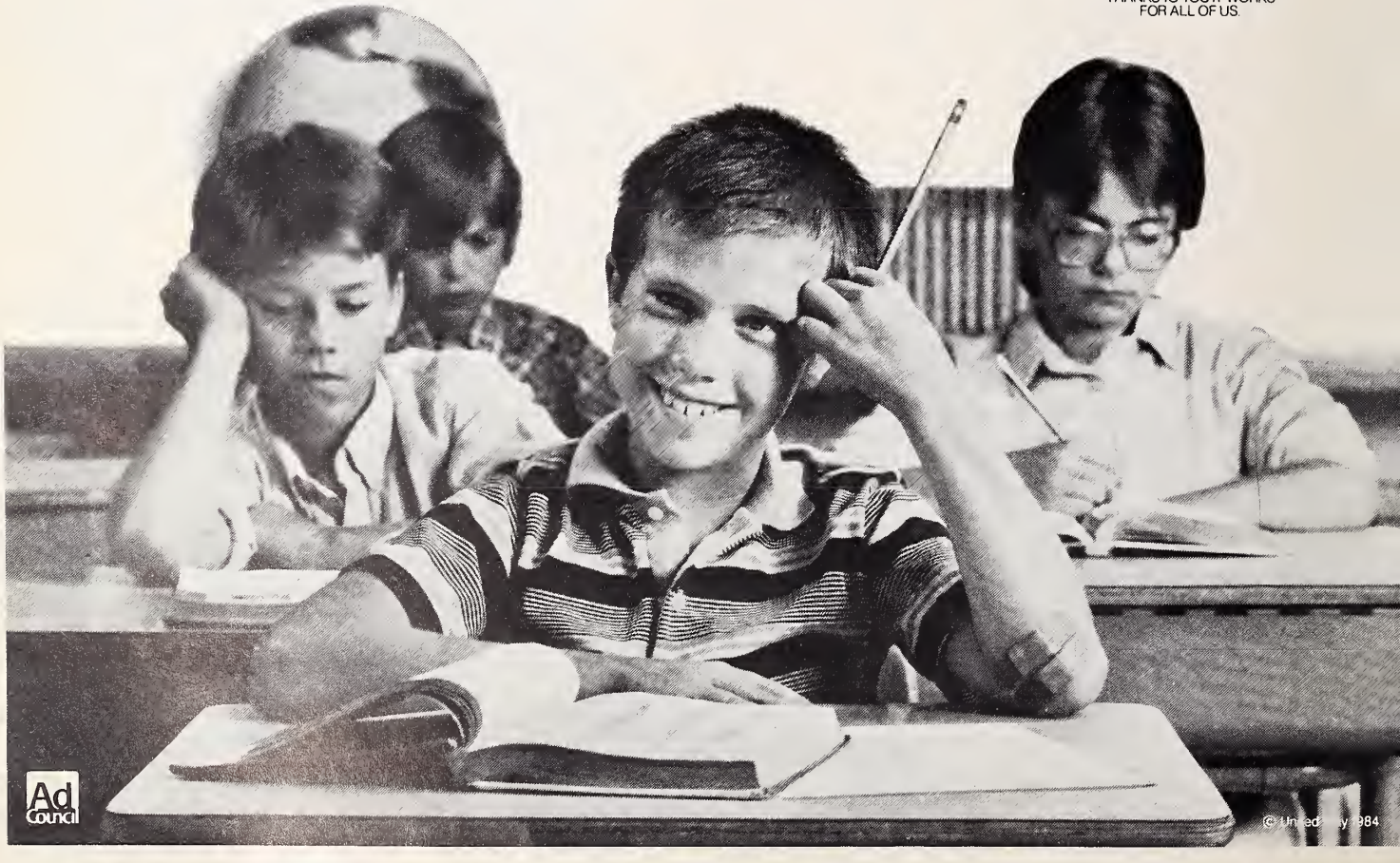
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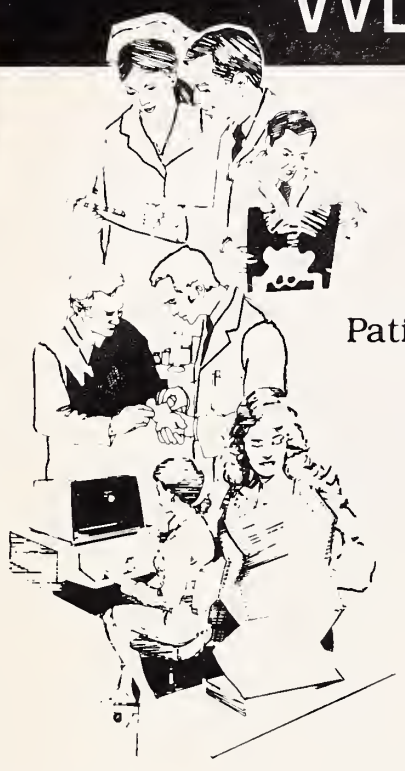
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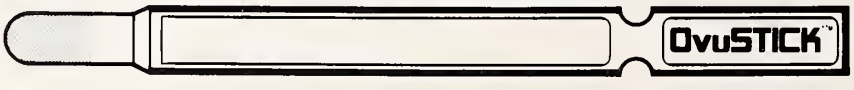
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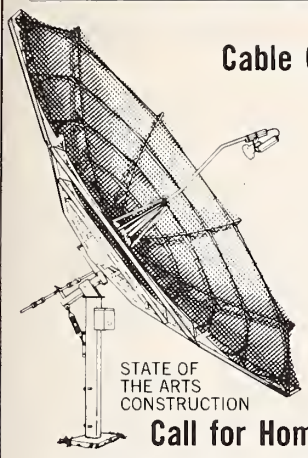


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SCIENTIFIC ARTICLES

Apocrine Cell Carcinoma

JAMES A. BARNETT, M.D., *Emporia*

Apocrine cell carcinoma is a rare tumor, first described by Cornil in 1865, with only 18 cases described in the literature by 1970. Subsequently, others have been described, but the tumor remains an uncommon malignancy.

Case Report

An 83-year-old white male presented in July of 1983 with a mass in his left axilla. It had been noted by the patient more than six weeks prior to initial evaluation. Originally the size of a golf ball, it gradually increased in size until the patient decided to seek medical attention. It was painless, although the skin had reddened and clear material drained from a superficial breakdown. Examination revealed a mobile 10 x 13 cm mass in the left axilla.

There were no palpable cervical, paraclavicular, right axillary, inguinal, or femoral nodes. The lungs were hyperresonant to percussion, and breath sounds were diminished throughout. There was no wheezing and no gross upper extremity lymphedema. The breasts were normal bilaterally.

A chest x-ray, obtained because of a long smoking history, revealed evidence of chronic obstructive pulmonary disease and no other pathology.

The patient underwent excisional biopsy, which revealed findings consistent with undifferentiated carcinoma. Further investigative studies were then undertaken to define the primary source of his tumor. He underwent bronchoscopy which revealed normal findings. An acid phosphatase was obtained which was normal at 0.46 units. Results of an upper gastrointestinal examination were unremarkable. A C-T scan of the abdomen with and without contrast revealed only cholelithiasis and tiny bilateral renal cysts.

The patient subsequently underwent a debulking procedure which revealed a partially encapsulated tumor. It was adherent to the surrounding pectoralis major and latissimus dorsi muscles, as well as the axillary vein and brachial plexus. The tissue diagnosis was that of a moderately well differentiated apocrine cell carcinoma.

Radiotherapy was advised for the patient following his recovery from surgery, but he declined this treatment. He currently remains free of evidence of recurrent disease.

Discussion

Apocrine cell carcinoma usually presents as a painless, slowly growing tumor. The distribution of the tumor follows the normal distribution of apocrine glands in the body. The axilla is the most common site, with occurrence also in the genitoanal, perimammary, periorbital and auditory canal regions, and less commonly in the thorax and abdomen. The tumors may vary from small to large, the largest recorded being 15 cm. The overlying skin is often red to purple and occasionally is ulcerated. Patients most commonly are affected in the sixth to seventh decades of life. However, sweat gland tumors have been described in adolescents. Most patients have noted the presence of the tumor for one year or less.

Apocrine gland carcinoma appears as an adenocarcinoma that may be poorly, moderately, or well differentiated. The characteristic histologic findings, demonstrated in this patient, include the presence of abundant homogeneous and granular eosinophilic cytoplasm. The appearance of pinched off cytoplasm in the lumen, which represents decapitation secretion present in normal glands, was also observed. (The prefix "apo" means "off," and this feature accounts for the name.)

Other typical features, also seen in this case, include the presence of iron-containing granules and of PAS-staining material.

Apocrine gland carcinoma of the axilla must be differentiated from carcinoma arising from ectopic breast tissue or an axillary tail of the breast. Addi-

(Continued on page 26)

Presented in abstract form at the American College of Physicians Regional Meeting, Topeka, March 9-10, 1984.

Address reprint requests to Dr. Barnett, 919 W. 12th Street, Emporia KS 66801.

Outpatient Inguinal Herniorrhaphies

FREDERIC C. CHANG, M.D.,* STACY L. PETERSON, M.D.† *and*
GEORGE J. FARHA, M.D.,‡ *Wichita*

In recent years there has been considerable emphasis directed at medical cost containment.[1-3] In the surgical field there has been a gradual decrease in the pre- and postoperative stay. The question now being raised is whether certain traditional in-hospital procedures can be performed on an outpatient basis. This study was undertaken to show that inguinal herniorrhaphies in adults may be performed safely on an outpatient basis. Our surgical group has performed more than 700 inguinal herniorrhaphies under local anesthesia during the past eight years. Sixty-six of these patients were admitted to the one day care unit and had their operations performed on an outpatient basis. These patients form the basis for this report.

Methodology

Sixty-six patients underwent elective inguinal herniorrhaphies under local anesthesia on an outpatient basis. All operations were performed between November 1975 and April 1984 at St. Francis Regional Medical Center in Wichita. All patients were operated upon by one of the two senior authors. Patients were selected based on their willingness to accept the procedure, residency within the community, and availability of assistance at home during the immediate convalescent period.

The age, sex, type of hernia, type of repair, operative time, amount of local anesthesia, and postoperative complications were recorded for each of the patients in this prospective study. A questionnaire, given to the patient one week postoperatively, evaluated patient acceptance, the amount of postoperative analgesia received and, when possible, a comparison between the recent herniorrhaphy and any previous herniorrhaphies or other operations performed under general anesthesia.

The patients were instructed to arrive at the one day care unit at least two hours prior to their scheduled operation. A brief history, vital signs, and routine laboratory work consisting of a complete blood count and urinalysis were obtained. One hour prior to operation the patient was moved to the preanesthesia care unit where intravenous fluids were started and premedication consisting of meperidine hydrochloride (50 mg), hydroxyzine hydrochloride (25 mg), and atropine sulfate (0.4 mg) was given. Intravenous diazepam in 2.5 mg increments was used to supplement the premedication when necessary. In the operating suite the patient was shaved and the skin prepared. Blood pressure and electrocardiographic monitoring were used during the surgery. The local anesthetic was a combination of 25 cc 0.5% lidocaine and 25 cc 0.5% marcaine, and an anesthesiologist was not utilized. The surgical technique remained the same as previously reported in 1977.[4] Postoperatively, patients were returned to the one day care unit where their vital signs were monitored. The recovery room was not utilized. Patients were not discharged until they were voiding without difficulty and tolerating fluids by mouth. They were then dismissed with acetaminophen with codeine phosphate or an equivalent for pain and instructed to return to the office in one week for followup care.

Results

The patients ranged between the ages of 18 and 81 years with an average age of 44 years. There were 63 men and three women. Seven patients were physicians, and seven had a history of previous surgery under general anesthesia, including one inguinal herniorrhaphy. Three patients had an inguinal herniorrhaphy utilizing the one day care unit one month after repair of the opposite side. Overall there were 46 indirect, 18 direct, one femoral, and one recurrent hernia. The various types of repair included high ligation and internal ring repair (1), Bassini (49), McVay (15), and insertion of Marlex mesh graft (1). The average operative time was 43 minutes with 31 ml of anesthetic solution being used. Postoperative complications included a vagovagal reaction which responded promptly to intravenous atropine, two incisions with moderate ecchymosis, and one patient who was nauseated and apprehensive at the

* Professor, Department of Surgery, UKSM-Wichita.
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From the Departments of Surgery, St. Francis Regional Medical Center and the University of Kansas School of Medicine-Wichita, and Wichita Surgical Group.

beginning of the procedure. Forty per cent of the patients required no postoperative analgesia. The remaining 60 per cent received an average of 3.9 acetaminophen with codeine tablets per person. No patients required hospitalization. Patient acceptance was 100 per cent, with all patients preferring local anesthesia as an outpatient if they were to have another hernia operation. The average hospital cost was $320 per patient.

No identical control group was available. However, a recent audit at our institution revealed that for 66 consecutive inguinal herniorrhaphies under general anesthesia there was an average postoperative stay of 2.3 days with 13 postoperative complications. Postoperative complications included urinary tract infection (4), urinary retention (3), wound hematoma (2), wound ecchymosis (1), atelectasis (2), and insertion of a nasogastric tube following coffee-ground emesis (1). At that time, the average hospital cost for an inguinal herniorrhaphy performed under general anesthesia as an inpatient was $1302, which was $982 more than that for the outpatient procedure under local anesthesia.

Discussion

Early in our experience with inguinal herniorrhaphies under local anesthesia we noticed that many patients could be dismissed the day of surgery. Consequently, we began utilizing the one day care unit, and now have used local anesthesia to perform 66 inguinal herniorrhaphies on 61 adult patients on an outpatient basis. The results indicate that this practice is both effective and safe. In fact, in comparing morbidity between outpatient surgery under local anesthesia and traditional inpatient surgery under general anesthesia, we confirmed our previous study[4] which showed a lower incidence of postoperative morbidity. Patient acceptance was also excellent. One of our initial concerns was that patients would require hospitalization because of a variety of postoperative complications. None of our patients required readmission to the hospital during the postoperative period. This is in contrast to the report by Abdu,[3] which reported that 18 per cent of their patients required hospitalization overnight following ambulatory care surgery.

At this time we do not have information regarding recurrence of hernias in outpatients because of the small numbers and short followup period. However, Flanagan[1] and Kingsnorth[5] have reported acceptable recurrence rates on their patients operated upon on an outpatient basis. In addition to being effective and safe, there is an obvious cost savings of $982 by utilizing the outpatient facility. This study confirms the findings of Flanagan[1] who reported a cost savings of $700 for local outpatient inguinal herniorrhaphies and Rockwell[2] who demonstrated a $502 savings in comparing outpatient versus inpatient inguinal herniorrhaphies under general anesthesia.

Summary

A prospective study was performed on 66 patients who underwent inguinal herniorrhaphies under local anesthesia on an outpatient basis at St. Francis Regional Medical Center between 1975 and 1984. The results from this study indicate that inguinal herniorrhaphies can be performed under local anesthesia on an outpatient basis. It is cost effective, safe, and well accepted by the patients. Based on this study we anticipate increasing use of our outpatient facility for performing inguinal herniorrhaphies under local anesthesia in adult patients.

References

1. Flanagan L Jr, Bascom JU: Herniorrhaphies performed upon outpatients under local anesthesia. *Surg Gynecol Obstet* 153:557, 1981.

2. Rockwell E: Outpatient repair of inguinal hernia. *Am J Surg* 143:559, 1982.

3. Abdu RA: Ambulatory herniorrhaphy under local anesthesia in a community hospital. *Am J Surg* 145:353, 1983.

4. Chang FC, Farha GJ: Inguinal herniorrhaphy under local anesthesia. *Arch Surg* 112:1069, 1977.

5. Kingsnorth AN *et al:* Recurrent inguinal hernia after local anaesthetic repair. *Br J Surg* 68:273-75, 1981.

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Anorexia Nervosa/Bulimia in a Male

PAUL REITH, M.D. *and* **KYUNG LEE, M.S.W.,** *Lawrence, and*
JOSEPH L. KYNER, M.D., *Kansas City, Kansas*

Eating disorders in women have been described and studied extensively. Although the true incidence of anorexia nervosa — weight loss associated with restricted eating — is not known, estimates vary from 1 to 5 per cent.[1] Bulimia, with gorging of food and self-induced vomiting, may occur in 40-50 per cent of college age women and — surprisingly — in 10 per cent of college age men. Also known as "bulimarexia," this disorder is considered a distinct entity with a more chronic history than simple anorexia nervosa.[2]

Hypothalamic-endocrine dysfunction, commonly described in women with anorexia nervosa, has been rarely described in men with this disorder. Women with self-induced starvation often have low gonadotropin and estrogen levels, with a delayed response of the gonadotropins to gonadotropin-releasing-factor. This is associated with amenorrhea. In a series of 101 patients with anorexia nervosa at the Mayo Clinic, only five were male, and low testosterone was measured in only two of them. These patients presented with impotence as the counterpart symptom to amenorrhea in women patients.[3] Otherwise, serum or urinary androgen levels have been described in only a few male patients who have met the criteria for diagnosis of anorexia nervosa or bulimarexia.[4-7]

Case History

A 23-year-old male college student presented in October 1982 complaining of increased fatigability with exercise. He admitted frequent (3-5/wk) episodes of binge-eating, followed by self-induced emesis with the vomitus occasionally blood-streaked. He described intermittent use of oral laxatives and rectal suppositories. Only when directly questioned did he admit loss of sexual interest and impotence.

Physical examination revealed a pale and emaciated young man, his oversize clothing masking a stooped and bony frame. He weighed 116 pounds, and at 6′2″ was 30 per cent below ideal weight for height. His visual fields were normal, facial hair was present, and his thyroid gland was normal in size and consistency. His ribs were prominant, but his chest configuration was normal. His heart was not clinically enlarged and heart sounds were normal; his resting pulse was 52 beats per minute. Axillary and pubic hair were present in a normal pattern. The right gonad was 3½ x 2½ x 2 cm; the left one was 4 x 2½ x 2 cm. The skin on his hands was especially rough from the frequent handling of vomitus.

Because of decompensation, he was admitted to the hospital where, except for time spent in classes, he stayed for one month in the more structured environment. The therapeutic goal was to explore his family relationships and to relieve his anxiety and depression. He gained ten pounds during hospitalization, but the cycles of binge eating and purging continued, although less frequently.

Discussion

The common medical complications of bulimarexia may include electrolyte abnormalities, such as hypokalemia and alkalosis. A reversible decrease in thickness of the ventricles and in left ventricular function may not cause symptoms. However, degeneration of myocardial cells can be associated with arrhythmia and sudden death. The anemia of anorexia nervosa may be associated with neutropenia and thrombocytopenia; it is an anemia due to bone marrow failure rather than to nutritional deficiencies of iron, folate, or vitamin B_{12}. Delayed gastrointestinal motility may present with abdominal bloating, glucose intolerance may be impaired, hypercholesterolemia is common, and premature osteoporosis is more prevalent with these disorders.[8]

On admission, our male patient's serum electrolyte levels were normal, and his cholesterol level was low normal. Hematologic workup revealed a normocytic, normochromic anemia with a low reticulocyte count, normal iron, folate and B_{12} stores, and stools negative for occult blood. A barium meal revealed no abnormalities in the esophagus or stomach.

Baseline hormonal values were determined from a single serum specimen because the patient refused more frequent samplings. A pooled sampling from

Presented in abstract form at the American College of Physicians Regional Meeting, Topeka, March 9-10, 1984.

From the Watkins Memorial Hospital, Lawrence and the University of Kansas School of Medicine, Kansas City, Kansas.

TABLE I

		Normals
T4 RIA	7.9 mcg/dl	5-12
T3 RIA	63.0 mcg/dl	90-175
TSH	3.4 μU/ml	0-6
LH	3.9 mIU/ml	2-10
FSH	2.1 mIU/ml	1-8
Prolactin	7.0 ng/ml	5-8
E1	56.0 pg/ml	25-75
E2	6.0 pg/ml	15-40
Testosterone	120.0 ng/ml	400-1200
Androstenedione	227.0 ng/ml	60-200
Cortisol	20.1 mcg/dl	10-20
DHEA-S	172.0 ng/ml	190-375

three drawings, 15 minutes apart, would have minimized fluctuating hormonal values and yielded more accurate results.

The hormonal results are shown in *Table I*. The very low T3 RIA in the presence of a normal total T4 RIA is compatible with decreased conversion of T4 to T3 in splanchnic organs by glucose sensitive 5′-diodinase accompanied by an increase in rT3, or "reverse T3." This is common in the malnourished, a condition found in the "euthyroid sick."[9]

Very low levels of serum gonadotropins (LH and FSH) are noted. These are almost prepubic values, a pattern similar to that seen in women with anorexia nervosa and amenorrhea, although these values are also at the lower limits of sensitivity of the assay.[10] The very low estradiol (E2) most likely resulted from lowered estrogen production due to reduced stimulation of the testes by gonadotropin.

The very low total testosterone level of 120 ng/ml (normal = 400-1200) is a unique finding reported only in a few male patients in world literature. A testosterone-binding-globulin level reading would have contributed to the interpretation of this finding. Interestingly, the serum androstenedione value was mildly elevated in the presence of normal estrone (E1), suggesting diminished aromatization of androgens to estrogens with minimal fat tissue.[11] Adrenal androgen and corticosteroid production appeared to be normal with high normal serum cortisol and normal dihydroepiandrosterone sulfate (DHEA-S).

It would have been desirable to perform a gonadotropin-releasing-factor test to detect a possible delayed gonadotropin peak, a finding often described in women with anorexia nervosa. However, the patient would not agree to further testing. He graduated from the University of Kansas in May 1983, and is now lost to followup.

References

1. Crisp AH *et al:* How common is anorexia nervosa? A prevalence study. *Br J Psychiatry* 128:549, 1976.
2. Halmi KA *et al:* Binge-eating and vomiting; A survey of a college population. *Psychol Med* 11:697, 1981.
3. Hurd HP *et al:* Hypothalamic-endocrine dysfunction in anorexia nervosa. *Mayo Clin Proc* 52:711, 1977.
4. Beumont PJV *et al:* The occurrence of anorexia nervosa in male subjects. *Psychol Med* 2:216, 1972.
5. Wesselius CL, Anderson G: A case study of a male with anorexia nervosa and low testosterone levels. *J Clin Psychiatry* 43:428, 1982.
6. McNab D, Wawton K: Disturbances of sex hormones in anorexia nervosa in an adolescent male. *Postgad Med J* 57:254, 1981.
7. Grossman ML: Depressive neurosis presenting as atypical anorexia nervosa in an adolescent male. *JCAM,* June, 1981.
8. Rigotte N: Assessment and management of medical complications of eating disorders in anorexia nervosa and bulimia (symposium), UKSM-Wichita, October 1982.
9. Calvaleiri RR, Rapaport B: Impaired peripheral conversion of thyroxine to triiodothyronine. *Annu Rev Med* 28:57, 1977.
10. Borghi A *et al:* Disorders of the hypothalamic-pituitary-ovarian axis in anorexia nervosa. *Endocrine Function of the Human Ovary* (James VHT *et al,* eds). London, Academic Press, 1976.
11. Schindler AE *et al:* Conversion of androstenedione to estrone in human fat tissue. *J Clin Endocrinol Metab* 35:627, 1972.

Letters to VOX DOX should be addressed to the Vox Dox Editor, Journal of the Kansas Medical Society, 1300 Topeka Avenue, Topeka, Kansas 66612.

Sleep Apnea Diagnosis in a Sleep Laboratory

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SHANNON B. HOOD, R.EEG T., *Wichita*

SINCE THE first polysomnographic recording of sleep apnea by Gastaut in 1965, there has been an explosion in knowledge and interest in sleep apnea. There are now 25 accredited and 35 provisional sleep disorders laboratories recognized by the American Association of Sleep Disorders Centers. One of these 60 laboratories opened in October 1982 at Wesley Medical Center in Wichita. During its first year of operation, 99 patients were referred for evaluation. Seventy-four were referred for suspected sleep apnea. Of this group, the diagnosis of sleep apnea was made in 38 (51%).

Methods

Patients referred by their physicians for suspected sleep breathing disorders were studied overnight and had continuous recording of EEG, EOG, EMG (submental and both tibias), ECG, ear oxymetry, air flow at the nose and mouth, and respiratory movement at the chest and abdomen. A video tape recording was also made. These patients also had a complete history and physical examination. Laboratory studies required before final diagnosis include CBC, arterial blood gases, T4, ECG, chest roentgenogram, and spirometry with flow volume loop. The BECK questionnaire to screen for depression is also done. Thirty-seven patients were studied for one night and 37 patients required a second night in the laboratory.

Results

Findings in the study are summarized in *Tables I* and *II*. Of 38 patients with a final diagnosis of sleep apnea, there were 34 males (89%) and four females (11%). In the 36 patients with negative studies for apnea, there were 26 males (72%) and ten females (28%). Ages of patients with sleep apnea and without sleep apnea were essentially identical for males, with the median being 54 years for both groups. The age range for males diagnosed as having apnea was 71-30 years. There was a difference in the female population. Median age of female apnea patients was 68 years and the median in the negative group was 55 years. The four females diagnosed with apnea ranged in age from 73-66 years old. There was a difference in weight between groups. Male apnea patients had a weight range of 350-145 pounds with a mean of 229 pounds and a median of 215 pounds. Males found not to have apnea had a weight range 288-40 pounds, a median of 185 pounds, and a mean of 192 pounds. Females with apnea had a weight range of 224-175 pounds, with a median of 233 pounds and a mean of 200 pounds. Females without apnea had a weight range of 274-22 pounds, a median of 175 pounds, and a mean of 151 pounds.

Chief complaints from patients with sleep apnea included excessive daytime somnolence (EDS) in 24, spouses observation of loud snoring or pauses in breathing in 16, nocturnal dyspnea in seven, nocturnal restlessness in four, and choking or gasping in three. Symptoms reported in the group found not to have sleep apnea were essentially the same with the exception of the spouse's observation of loud snoring or pauses in breathing, which was noted only once. Although not necessarily a complaint, all patients with apnea snored. Thirty patients (83%) in the non-apnea group snored by history or laboratory observation.

Within the group of diagnosed apnea patients, 24 had obstructive apnea, six had central apnea, and eight had a combination of obstructive and central apnea. The number of apneas recorded on the positive studies ranged from 695 with an apnea index of 98 to 36 apneas per night with an index of 6. Three of the patients with obstructive apnea also had documented narcolepsy. In these patients, the narcolepsy appeared to be primarily responsible for their symptoms. All patients diagnosed as narcoleptic had positive multiple sleep latency tests. Other polysomnographic diagnoses made on patients studied for apnea included an additional four patients with narcolepsy; night terrors, two; nocturnal desaturation without apnea, seven; sleep stage disturbance, one; insomnia, two; nocturnal myoclonus, three; profound nocturnal sinus bradycardia, one; and abnormal frequent arousals, one. There were 14 normal polysomnographic studies. Therefore, some degree of sleep pathology was identified in 60 patients (81%).

Nine patients required surgical therapy because of

Presented in abstract form at the American College of Physicians Regional Meeting, Topeka, March 9-10, 1984.

TABLE I

	Apnea (38)		*No apnea (36)*	
Sex	M (34)	F (4)	M (26)	F (10)
Age, median	54	68	55	55
Range	71-30	73-66	88-1	75-1
Mean weight	229	200	192	151
Snoring	38 (100%)		30 (83%)	

TABLE II

Chief complaint	*Apnea (38)*	*No apnea (36)*
Daytime somnolence	24 (63%)	22 (61%)
Spouse observed snoring or apnea	16 (42%)	1 (3%)
Nocturnal dyspnea	7(18%)	13 (36%)
Restlessness	4 (11%)	1 (3%)
Choking/gasping	3 (8%)	2 (6%)

profound nocturnal arrythmias, desaturation, or disabling daytime symptoms. These included tracheostomy, five; uvulopalatopharyngoplasty, three; and tonsillectomy and adenoidectomy in one. Patients with less severe apnea were treated conservatively with weight loss and in selective cases protriptyline or medroxyprogesterone. Patients with central apnea were treated initially with acetazolamide.

Discussion

As has been previously recorded, sleep apnea is predominantly a disorder of middle-aged and late middle-aged males as was the case in our experience. The four females who were diagnosed with apnea were all post-menopausal and obese. Age in the male population does not seem to be a predictor of a positive study, but there was a significant difference in the female population in age ranges between those with positive and negative studies. Overall, the male patients with apnea were overweight, but again this seems to have no predictive value, as there was a considerable overlap between the two groups. The best single clinical predictor of apnea was the spouse's observation of loud snoring or abnormal breathing pattern at night. Because of this, a patient's bed partner should be involved in the clinical interview.

The number of apneas per night in this series seems lower than that in some previous reviews. In the apnea group, 13 patients had fewer than 100 apneas per eight hours of sleep. This may be an indication that there is more physician and patient awareness of sleep apnea and patients are likely to seek medical attention before they develop the full-blown clinical syndrome of sleep apnea. Since it is not known if some of these cases of very mild apnea will become more significant in the future, patients with apnea too mild to require treatment are advised to consult their physicians if they develop increasing EDS or hypertension. Weight gain often seems to increase the number and severity of apneas in a given individual.

Patients suspected of having sleep apnea, but whose studies were negative, often were found to have other sleep pathology. Because of this and the fact that clinical symptoms alone are not always good predictors of the outcome of a polysomnographic study, all patients suspected of having sleep apnea should have a comprehensive test.

It was interesting to discover both obstructive sleep apnea and narcolepsy in three patients. There is no known association between sleep apnea and narcolepsy. These findings suggest that if the degree of apnea does not correlate with the severity of symptomatology, especially EDS, or if treatment of apnea or narcolepsy does not relieve EDS, then a co-existing sleep disorder should be considered.

Mark your calendar . . .

AND COME TO THE BROADMOOR!

KMS 1985 Annual Meeting
May 2-5, 1985

The Broadmoor **Colorado Springs, Colorado**

KMS

Kansas Medical Society Newsletter

January, 1985

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PROFESSIONAL LIABILITY UPDATE

At its last meeting, the KMS Professional Liability Committee approved the legislation which will be introduced to bring about some reasonable reform in the medical malpractice area. It is expected that the legislation will be introduced a couple of weeks after the session convenes on January 14. The proposals contain about eight separate points, but the major aspects are summarized below:

1. Limit on Awards. A $500,000 limit on total awards is proposed. Included in the proposal is a "safety valve" provision which allows for the payment of extraordinary medical costs, even if such costs exceed the general $500,000 limitation. This provision was put in to assure that in exceptional cases, the most critically injured patients would be able to have their medical expenses paid.

2. Limit on Pain and Suffering Awards. A $100,000 limitation on the amount of damages that can be awarded for "pain and suffering," has been proposed.

3. Punitive Damages. Punitive damages in medical professional liability claims would be eliminated entirely.

4. Collateral Source Benefits. Evidence of benefit payments from collateral sources would be made available to juries, so plaintiffs don't receive a windfall or get aid twice for medical costs, etc.

5. Attorneys Fees. A 15% limitation upon attorneys' fees is proposed on all awards over the basic insurance requirement of $200,000. This approach would result in attorneys receiving 15-20% of awards, as opposed to 35-50% of awards currently.

In the next couple of weeks KMS will be distributing a "mini-brochure" to every member which will be available in quantity. The mini-brochure would be suitable for mailing to patients, keeping in waiting rooms or other general distribution. It will summarize information from our earlier large brochure. KMS will also be releasing results from its public survey on medical malpractice issues very shortly.

If you have not already contacted your legislator about the professional liability situation, please do so. A brief letter or phone call expressing your interest in the subject and encouraging him/her to support the KMS bill when it is introduced will be very helpful. If you have any questions about our program, or need additional information, please call the KMS office.

n This Issue...

Professional Liability Update
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AMA Leadership Conference
HCFA Cost Data Survey
Physician Utilization Trends
Right to Die Preferred
Annual Meeting 1985

1985 DUES

KMS dues for 1985 are now due and payable. This is also a reminder to remit the special assessment for the professional liability project, if you have not already done so. Thank you!

We'd like to specially thank and recognize those members who have chosen to contribute more than $100 to this effort. Since the publication of the December Newsletter, higher levels of support were received from the following physicians:

Gold Club ($1,000 & Over)
Franklin G. Bichlmeier, M.D.
Michael D. Boggan, M.D.
Shawnee Mission Medical Ctr.

Silver Club ($500-999)
Leslie W. Nesmith, M.D.
Edward J. Robertson, M.D.
John D. Robinson, M.D.
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Kirk Wanless, M.D.
Dale Watson, M.D.

Special thanks to the Wichita Clinic, Wichita, which supported the KMS efforts with $6,800 on behalf of its physicians and the Kansas Hospital Association for their $10,000 contribution.

THE RIGHT TO DIE

Almost 33% of patients who survived cardiac arrest would have preferred death to cardiopulmonary resuscitation, according to an article by two physicians writing in the New England Journal of Medicine.

A study evaluating 154 patients resuscitated in 1981 at Beth Israel Hospital in Boston shows that 30% of the 24 mentally competent survivors interviewed said that they had not desired resuscitation and did not wish to be resuscitated again in the future. However, only one of the 16 physicians who had cared for these patients believed that they had not desired resuscitation, according to the researchers. Moreoever, none of the cardiopulmonary resuscitation survivors studied six months after they were discharged from the hospital were found to be demented or depressed, yet each reiterated a desire not to be resuscitated.



The BROADMOOR
COLORADO SPRINGS, COLORADO

REMEMBER! KMS Annual Meeting, May 2-5, is something SPECIAL! Draw intellectual nourishment from the professional program on Physician Responsibilities & Medical Ethics; draw physical nourishment from your choice of recreational activities; draw spiritual nourishment from the idyllic Colorado Springs environment.

COME TO LEARN . . . COME TO SERVE . . . COME FOR FUN!

LUE CROSS ACTIVE IN PPAs

A recent report released by the American Hospital Association indicates that Blue Cross has been actively developing preferred provider arrangements across the nation over the past two years. While the specifics of each PPA vary, in general they can be characterized by having:

-- A Pricing Agreement between BC and providers (hospitals/physicians) ranging from a discount from full charges to prospectively fixed price agreements using per diems or DRGs.

-- Extensive Utilization Review typically involving preadmission certification and a review of length of stay. The preadmission certification insures appropriateness of care, but in most situations it does not certify the admission as being medically necessary. Concurrent review of length of stay determines that continued hospital stay is necessary.

-- Financial Incentives for Subscribers to Use PPA Providers: Out-of-pocket costs to subscriber (deductibles/co-pays) are reduced when a preferred provider is used.

-- A Method of Selecting "Preferred Providers": UNLIMITED - Participation allows all providers within a geographic area to decide independently whether to participate. Any provider agreeing to contract will be granted preferred status. LIMITED - Participation/Competitive bidding - Generally designates a specific number of providers as preferred. Key considerations of such selection are price, geographical location and BC subscribers' historical use of hospitals.

Blue Cross PPAs are marketed primarily in urban areas where there is a sufficient number of competing hospitals. Limited participation approach appears to be favored, with the fixed, prospectively determined price system as preferred pricing mechanisms.

CHOICE CARE"

Meanwhile in Kansas, BC/BS is preparing to launch its PPA, Choice Care. Choice Care will be a coordinated effort between hospitals, physicians and BC/BS, and will be based on price competition. Hospitals will be asked to submit competitive bids based on fixed DRGs. PPA providers would be paid 75% of their charges or MAP, whichever is less. The remaining 25% would comprise a shared risk fund for settlement at year's end. Two hospitals each will be chosen in Topeka and Wichita to participate. More detailed information on this topic will be forthcoming as it develops.

THE FREEZE DEEPENS

The government proposal to extend the Medicare fee freeze for hospitals and physicians was met with dismay. While the physicians will continue to provide for the best possible

care for their patients, organized medicine is and will be reminding the Administration and Congress of their obligations to fulfill the Medicare contract as it was initiated, without depriving the elderly of the high quality medical services. It is suggested that the government look to equitable budget cuts across all government programs, not just health.

LEADERSHIP CONFERENCE

The 1985 AMA National Leadership Conference will open at 5:30 p.m. Thursday, February 14, and close at 3:30 p.m. Saturday, February 16, at the Palmer House in Chicago. A series of eight optional seminars will be available on Thursday. The meeting is open to all physicians. For more info, contact the KMS office.

GOVERNMENT SURVEY

The Health Care Financing Administration (HCFA) is conducting a survey among physicians designed to collect and analyze current administrative and practice costs data and physician fees. The purpose of the study, "The 1984 Physicians Practice Costs Study," will guide HCFA in updating and adjusting Medicare reimbursement procedures, as well as provide information relevant to important federal health policy issues, including physician participation in public programs, current practice arrangements and individual physician relationships with hospitals. The study is being conducted for HCFA by the National Opinion Research Center, which is affiliated with the University of Chicago. Total physician sample is 5,000. The AMA has cooperated by providing at-random physician names by geographic areas.

The AMA and KMS neither endorse nor oppose physician participation in any survey conducted by outside organizations. This particular study, to a certain degree, duplicates portions of the socioeconomic monitoring system (SMS) study conducted by AMA on an ongoing basis.

PHYSICIAN UTILIZATION DECLINES

According to a recent issue of the AMA Newsletter, utilization of physician services declined almost continuously from 1982 through the first half of 1984, possibly signaling a slowdown in growth in the health care sector, according to the Socioeconomic Monitoring System of the AMA Center for Health Policy Research. The decline occurred in the numbers of both office and hospital visits. Total patient visits had increased from slightly more than a billion in 1975 to approximately 1.5 billion in 1982. This growth, however, appears to have ended in 1982. Between 1982 and 1983, total visits -- including office visits, visits on hospital rounds, and visits to hospital emergency rooms, outpatient departments, and other settings -- showed a slight decline. Despite the increase in total visits from 1975 to 1982, the rapid growth in the number of physicians contributed to a slight percentage decline in the number of visits per physician (0.8%) during the same period. From 1982 to 1983, the downward trend in the number of visits per physician accelerated by 5.2%. If these trends continue, SMS concluded, competitive pressure can be expected to increase as the market tightens.

CURRENT COMMENT

The High Risk Cardiovascular Patient

C. A. DUJOVNE, M.D., *Kansas City, Kansas*

Arteriosclerosis may be directly or indirectly responsible for as many as 70 per cent of all illnesses or deaths. Arteriosclerosis-prone individuals could be easily identified by early determinations of cholesterol levels in the various lipoprotein fractions of serum and by documentation of family history that demonstrates a propensity to accelerated arteriosclerosis. Lowering serum cholesterol has now been shown to decrease morbidity and mortality from cardiovascular disease.[1]

Set out here are abbreviated guidelines for the detection and correction of serum lipid abnormalities in subjects at risk for premature or accelerated cardiovascular morbidity or mortality:

—siblings or children of patients affected with coronary artery disease prior to age 60 years; and
—individuals who have a family history denoting premature arteriosclerotic cardiovascular disease (PASCVD) morbidity and mortality in any family member, such as: symptoms of transient ischemic attacks (TIA), peripheral vascular insufficiency (PVI), coronary insufficiency (CI), carotid stenosis (CS), myocardial infarctions (MI), or strokes (CVA).

To identify the candidates for PASCVD in whom screening of serum cholesterol is imperative, a careful family history must be obtained from all patients. It is more relevant to determine the age at which the relative(s) became symptomatic than to learn the age at death. Current medical advancements allow for multiple episodes and long-standing conditions; therefore, age of death from the consequences of arteriosclerosis may not reflect the premature occurrence of this condition. Levels of serum lipids may provide a clue to the likelihood of accelerated arteriosclerosis and help to identify the type of lipoprotein metabolism abnormality *(Table I)*. Anyone with a total cholesterol level, in mg/dl, greater than the number 200 plus age in years, must undergo a determination of serum cholesterol lipoprotein fractions; these latter studies must be done on a blood sample drawn in the morning after a 12-hour fast.

From the Lipid and Arteriosclerosis Prevention Clinic, Division of Clinical Pharmacology, Department of Medicine, The University of Kansas School of Medicine-Kansas City.

Address reprint requests to Dr. Dujovne, UKSM-KC, 39th & Rainbow Blvd., Kansas City KS 66103.

Initial Recommendations

For patients with low density lipoprotein (LDL) cholesterol levels between 170 an 200 mg/dl without family history of PASCVD:

- Prescribe diet by providing patients with NIH booklets #80-112, 113 or 115, or by the standard recommendations to progressively decrease cholesterol intake from a maximum of 300 to below 100 mg/day and increase polyunsaturated fat ratio.[2]
- Prescribe physical aerobic exercise treatments, to be given in stepwise fashion.
- Allow two to three months of diet and aerobic physical exercise treatments to exert their effects, performing evaluations of serum lipids once a month.
- The goal is to reduce abnormal levels of LDL cholesterol to below 170 mg/dl or to the lowest possible level.

For high risk individuals, if LDL cholesterol levels remain above 170 mg/dl despite diet and exercise treatments, consider hypolipidemic drug/s therapy. The drugs and dosage ranges most commonly utilized at our clinic are shown in *Table II*, together with a list of their most common side effects.[3]

Serum triglyceride elevations are not to be treated with drugs unless levels are consistently greater than 500 mg/dl.

Anti-platelet Aggregation Therapy

Dyslipidemia is commonly associated with enhanced platelet aggregation which increases the cardiovascular risk of patients with abnormal serum lipids; consequently, demonstrable present or past TIA, PVA, CI, MI, CS, or CVAs should be treated

TABLE I
DIAGNOSIS OF MOST COMMON DYSLIPIDEMIA CONDITIONS BY SERUM LIPID LEVELS

Diagnostic Type	*Lipid Level Abnormality (mg/dl)*
Isolated hypercholesterolemia (Type IIA*):	LDL cholesterol > 170†
Combined hyperlipidemia (Type IIB*):	LDL cholesterol > 170 Triglycerides > 200
Combined hyperlipidemia with disproportional VLDL‡ cholesterol elevation§ (Type III*):	LDL cholesterol > 170 Triglycerides > 200

* Types from the World Health Organization classification criteria.
† Can be calculated by formula:

$$\text{LDL Cholesterol} = \text{Total Cholesterol} - \left(\frac{\text{Total Triglycerides}}{5} + \text{HDL}\| \text{Cholesterol}\right)$$

‡ Very Low Density Lipoprotein
§ Needs to be confirmed by lipoprotein electrophoresis showing a broad "floating" beta fraction or by determination of a very low density lipoprotein cholesterol serum triglycerides ratio > 0.3.
‖ High Density Lipoprotein

with inhibitors of platelet aggregation. The newly discovered role of prostacyclin — a platelet anti-aggregant secreted by arterial endothelium — and the possibility that its secretion may be inhibited by a large dose of aspirin, has changed the recommended dosage of this drug. A dose of aspirin of 25-50 mg/day is sufficient to inhibit the proaggregant

(Continued on page 31)

TABLE II
COMMONLY USED HYPOLIPIDEMIC DRUGS

Indication and Drug	*Dosage*	*Side Effects and Toxicity*	
		Common	*Uncommon*
Hypercholesterolemia			
Cholestyramine (Questran)	8-24 gm/day (mixed with 4-6 oz of suitable liquid) given in 2 or 3 divided doses before meals	Dyspepsia, constipation, nausea, abdominal pain, exacerbation of symptoms from hemorrhoids, anal fissures or hernias, interference with absorption of other drugs	Vomiting, skin rash, easy bruising
Colestipol HCl (Colestid)	10-30 gm day (mixed as above)	Same as above	
Probucol (Lorelco)	500 mg (2 tablets) with meals bid	Increased bowel movements. Prolonged QT interval at ECG	Diarrhea, dyspepsia, skin rash
Severe Mixed Hyperlipidemia			
Nicotinic acid (Nocobid, Noco-400, Nicolar)	3-5 gm/day, given in 3 divided doses	Flushed skin, itching, dyspepsia, decreased glucose tolerance, hyperuricemia, abnormal live function tests	Hepatotoxicity, diabetes, gout, peptic ulcer
Hypertriglyceridemia			
Gemfibrozil (Lopid)	600 mg, bid	Increased LDL cholesterol levels	Abnormal liver function tests, increased gallstones incidences and GI cancer by Clofibrate; effects of gemfibrozil are not well known
Clofibrate (Atromid)	1 gm bid	Same as above	

PRESIDENT'S MESSAGE

Poor Prichard's Medical Almanac

A stitch in time saves blood.

A chance to cut is a chance to cure.

Unlike the automobile mechanic, the physician cannot guarantee results. The physician can guarantee only the quality of his/her workmanship.

An emergency is an elective situation that has gone to seed.

Operating room sterility is like public morality — if you get close enough (to becoming contaminated) that anyone has the slightest question, you have already gone much too far.

A physician's mate can be a beloved partner, but never a spouse; the physician is married to medicine.

A physician should try to persuade patients to be his/her friends, but not friends to be patients.

The accident totaled the car — and the driver.

A cure is often not possible. An appendectomy does not cure the 7-year-old with the ruptured appendix; it only palliates for another 70 years.

Manufacture stimulates distribution as invention provokes need.

With the goals of improving the quality and decreasing the cost of medical care, worse than having too few physicians is having too many.

In our own lives, we must individually experience the entropy of the universe.

Research often means to hunt again for that which was forgotten, misplaced, or overlooked.



Discovery may be confused with creation.

Chronicity fatigues acute responses.

Confidence and competence are not necessarily proportional.

Every physician practices experimental medicine. Precisely the same illness or set of pathological circumstances has never before occurred in the history of the world. Each patient is new and unique.

F. Calvin Bayles, M.D.

President

EDITORIAL COMMENT

The Chosen People

The coincidence of coming upon two apparently dissimilar articles recently has brought a reminder of the continuing problem of selecting for admission to the medical ranks those individuals best suited to fulfill the considerable obligations of the profession. The problem stems in part from the certainty that all physicians, regardless of the forms of service they will subsequently follow, should be indoctrinated in the common groundwork of patient care.

One article, in the *Medical Care Review* published by the Health Administration Press of the University of Michigan, examined physicians' background characteristics in relation to their career choices and, whether intended or not, puts emphasis on the ubiquitous dichotomy represented by the clinical and academic divisions. The other, a discussion by Dr. Stephen Mellinek in a recent issue of *The Pharos,* presented some reflections on the functions of the two sides of the brain as represented by these two groups, at once interrelated and mutually dependent yet conflicting in certain essential qualities.

Medical school admission committees are, by basic purpose, charged with choosing those applicants who will be the most suitable and productive practitioners. In their pursuit of that purpose, they are the frequent recipients of unwanted advice from various quarters and one of the more frequent admonitions is that there should be less of the sciences in premedical preparation and more of the humanities. Today's version is a reaction against the intrusion of excessive technology in medical practice, and the proponents seem frequently under the impression that this is a new thought. We can testify from our own experience that the same thought was being expressed 50 or more years ago when heavy doses of undergraduate science were thought to grease the gates of the medical establishment. Historically, there was a time when the sciences did play a lesser role since they were far less developed than today while the humanities were more prominent — but so were they in all branches of study in the days when education was an even greater luxury.

If, indeed, there is this relentless repetition in the matter, the current world has introduced a new element for consideration, the diversion of more and more physicians away from direct patient care and into administrative and ancillary roles. The feeling is strong that such individuals, as we noted, should bring a preparation in the standard medical curriculum and patient contact, a feeling supported by a degree of truth but strengthened also by the reluctance of a strongly traditional profession to give up any of its fundamental concepts.

Is there a danger that this will become an unnecessary and unsupportable drain on medical education resources? Should there continue to be a prerequisite that such individuals should have a certain amount of experience with direct patient care before embarking on such administrative duties (as some now advocate a period of general practice for new physicians before they embark on specialty training)? Should we further complicate the problems of the admissions committees by expecting them to detect before the fact which applicants are more likely to take the administrative path? If so, it seems unlikely with current methods that there can be any effective method to regulate the matter without courting criticism of resorting to quotas or risking suits for discrimination. Should we adopt another category of practice comparable to the Army's Medical Administrative Corps?

For the moment, then, we see the applicant as a partially filled vessel bringing to the project a brain of two sides into which some unknown intake valve will regulate the proportionate flow. Perhaps we can't improve on the system reportedly adopted by the armed services during WWII to determine soldiers best suited for tropic or arctic duty. After exhaustive studies, it was found that the best method was to ask whether the soldier liked hot or cold weather better. — *D.E.G.*

SPECIAL FEATURE

The Honorable Jack D. Walker, M.D.

Dr. Walker or Senator Walker? On January 15, Jack Walker traded his black bag for brief case, his PDR for the Kansas Statutes Annotated, and became Kansas' only physician legislator.

"I plan to listen a lot," said Walker as he approached his freshman term. "I have expertise in health care and in education, and I hope to make a contribution in those areas. I'll be weighing other issues in order to do the best job possible for all of the people in Kansas."

No novice to Kansas politics, Dr. Walker was mayor of Overland Park from 1971 to 1977. During his tenure, he also served as chairman of the Johnson County Council of Mayors and as president of the League of Kansas Municipalities.

"My mayoral experience has given me a broad range of interests," notes Walker, "and perhaps I gained some expertise that will be useful in my legislative endeavors."

Dr. Walker was graduated from the University of Kansas School of Medicine in 1953. He practiced family medicine in Girard and Pittsburg until 1963 when he became associate dean at UKSM. In 1971, he was appointed first chairman of the newly created Department of Family Practice, a position he held until 1982. Under his leadership, the department achieved national recognition in the field of family medicine and the training of family physicians.

Dr. Walker is a 27-year member and charter Fellow of the American Academy of Family Physicians, and was an active promoter of the concept of a specialty of family medicine and the establishment of the specialty Board of Family Medicine.

Senator Walker won a primary contest with longtime State Senator Paul Hess, who had moved into the district from Wichita. This victory dealt the seat to Walker, as he was unopposed in the general election for the position vacated by Jan Meyers, who was recently elected to Congress.

Although historically a number of physicians have contributed their efforts to the Kansas legislative process, Senator Walker is the first to serve in the Senate since I. E. Nickell, D.O., Smith Center, left in 1956. No physician has held a seat in the House since Edward F. Steichen, M.D., Lenora, completed his service in 1974.



Senator Walker anticipates that this legislative session will be dominated by financial factors.

"Money will be the big issue. The uncertainty of federal funding could have a serious impact. I look for an austere and sober session.

"Of course, the professional liability problem is of primary significance to the medical community. Litigation of all types — not just medical — is out of control. Some effort must be made to bring it under control across the board."

In accordance with Kansas Board of Regents policy, Dr. Walker will be on leave of absence from UKSM during the legislative sessions.

Although technically his district encompasses only one-third of Johnson County, Senator Walker will no doubt find himself with a state-wide constituency as the legislature turns its attention to medical issues.

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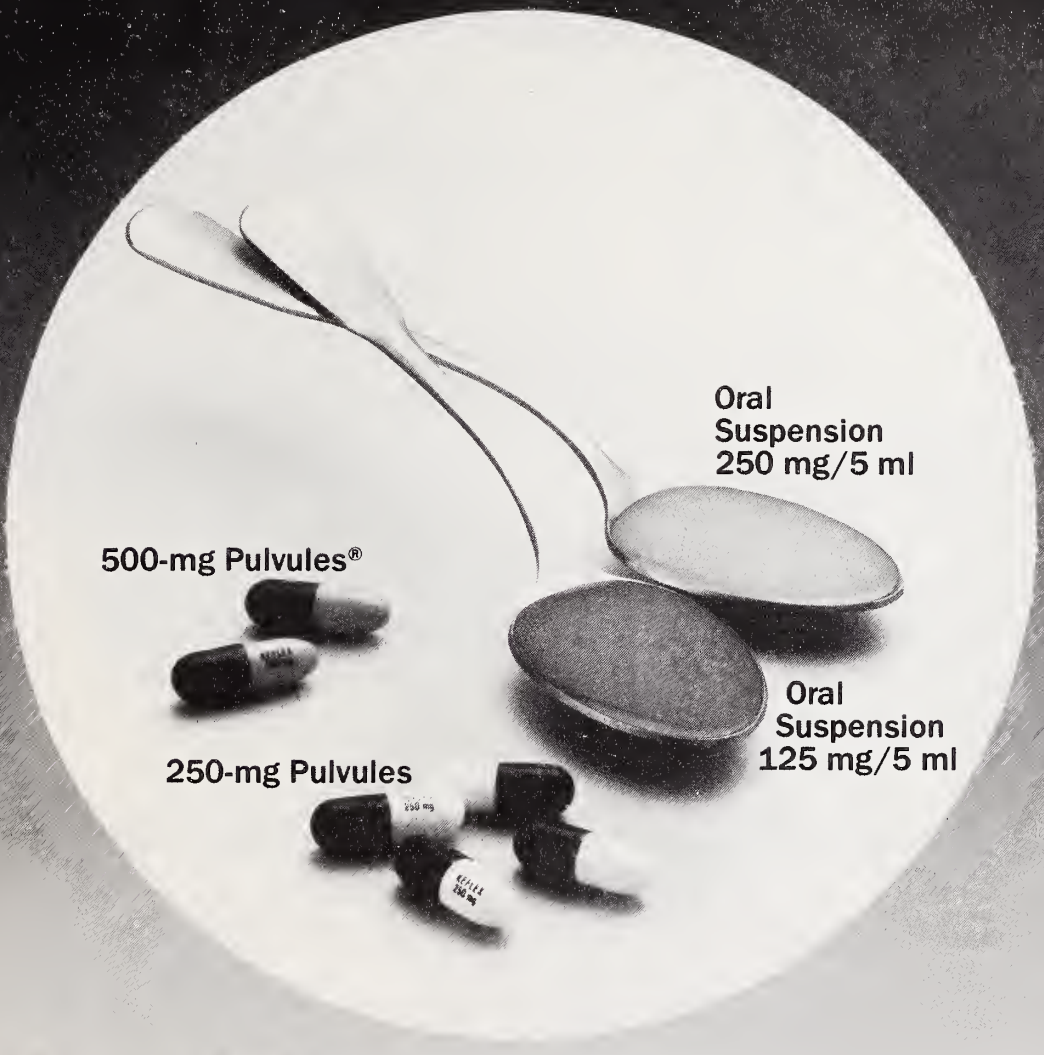
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VOX DOX

Vox Dox Editor:

The recent midwest and Kansas jury verdicts that assessed multi-million dollar punitive damage awards have alarmed many thoughtful and concerned Kansans. It is especially significant because actual damage jury verdicts appear to go so far beyond compensating injuries that they punish where no punishment was intended and are almost punitive because of their size.

Some interest groups are suggesting the abolishment of punitive damages. They note the growing number of legal scholars who question the wisdom of punitive damages in civil negligence cases and suggest that assessment of punishment should be relegated to the area of criminal law.

On the other hand, an equal number of legal authorities subscribe to the view that punitive damages still serve a legitimate public purpose in protecting the public from misconduct that is characterized as wanton, reckless, malicious, and indifferent.

If one subscribes to the latter view, the question remains as to why a plaintiff who has been fully compensated for his/her injuries by an actual damage verdict should have the windfall of a punitive damage verdict, particularly since one of the justifications for punitive damages is its protection of the public. It follows, then, that punitive damages should benefit the public generally.

The Kansas Association of Defense Counsel, a group of attorneys who specialize in the defense of civil law cases, will suggest an alternative to the present punitive damage system to the 1985 Kansas Legislature. The KADC-sponsored Kansas Punitive Damage Reform bill will provide for cases that involve punitive damages to be tried in two phases. The first phase will decide the issue of whether punitive damages are to be assessed; once that issue is resolved, a separate trial to the judge alone will determine additional circumstances and actual amounts of punitive damages. Five per cent of any punitive damage award would go to the plaintiff; the balance would be paid into the state general fund. Thus, punitive damages would remain a deterrent to wrongdoers without creating a potentially massive windfall for a particular claimant. The public would be the primary beneficiary and the plaintiff would receive some compensation.

The bill also provides that no evidence of the defendant's financial condition is admissible during the first phase of the trial. Thus, a jury's assigned task — the determination of fault and actual damages — will not be biased by the defendant's financial status, but will be focused entirely on determination of the defendant's fault.

At present, several progressive trial judges are employing the general concept of split trials. The results reportedly are favorable for all concerned.

The KADC welcomes support for the bill from the public and the medical and legal communities. The KADC believes its bill retains the concept of punitive damages as a protection for the public but also provides a number of safeguards that are needed in today's society.

John J. Jurcyk, Jr.
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Apocrine Cell Carcinoma

(Continued from page 10)

tionally, metastasis from an occult primary breast malignancy is possible. The breast is actually a collection of modified sweat glands, and a primary breast tumor may be difficult to distinguish from sweat gland carcinoma. The presence of neoplastic glands high in the dermis favors a diagnosis of sweat gland carcinoma. Metastatic axillary neoplasms from other occult primary malignancies must be excluded as well.

The treatment of choice for apocrine adenocarcinoma is surgical excision. Well differentiated sweat gland carcinoma has been treated by surgical excision alone with reasonable success, but less differentiated tumors are best treated with wide local excision and lymph node dissection.

There is limited information regarding the use of chemotherapy for control of these tumors. Radiotherapy has been tried with uncertain success.

Prognosis for survival following definitive treatment for apocrine adenocarcinoma is difficult to assess due to the rarity of the tumor. From Miller's review of the literature, 72 per cent of patients eventually developed metastasis to lymph nodes. Previous studies have indicated a correlation between the degree of differentiation of the tumor and survival. For well differentiated tumors, the five year survival rate has been as high as 70 per cent. For poorly differentiated tumors, the survival rate has ranged from 0 to 17 per cent in five years.

Summary

Sweat gland carcinoma is a rare tumor, most commonly found in the axilla. The histology is that of an adenocarcinoma with the characteristic histologic findings of eosinophilic cytoplasm, evidence of decapitation secretion, and iron staining granules. The primary treatment of the tumor is that of surgical excision. The prognosis is favorable for patients with well differentiated tumors.

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New study reveals no interaction betwee



Ativan® (lorazepam) and Darvon® (propoxyphene HCl) Ⓒ Ⓘ Ⓥ

In a study evaluating the influence of propoxyphene coadministration on the pharmacokinetics of the oxidatively metabolized benzodiazepines Xanax® (alprazolam) Ⓒ and Valium® (diazepam) Ⓒ, and a benzodiazepine metabolized by conjugation, Ativan® (lorazepam), the following results were reported:

with Xanax, propoxyphene caused a large and highly significant prolongation of half-life and impairment of total metabolic clearance.[1]

in the case of Valium, propoxyphene produced a small but not statistically significant impairment of clearance.[1]

propoxyphene had no apparent effect on the distribution, half-life or clearance of Ativan.[1]

In this randomized crossover study, eight healthy male and female volunteers received single oral doses of alprazolam (1 mg), six received single IV doses of diazepam (10 mg), and five received single IV doses of lorazepam (2 mg), once in a drug-free control state and again during coadministration of propoxyphene (65 mg q6h). Consistent with previous findings, this study evidences that Ativan does not interact with drugs that undergo oxidative metabolism.[2-5] In contrast to most other benzodiazepines, Ativan does not compete for the cytochrome P-450 enzyme system.

The clinical implications of the pharmacokinetic interaction, or non-interaction, of propoxyphene with benzodiazepines are not established by this study. Even without a pharmacokinetic interaction, propoxyphene and benzodiazepines share central depressant properties and therefore should be coadministered with suitable caution. A concurrent pharmacokinetic interaction indicates a need for even further caution. Coadministration of propoxyphene and alprazolam, for example, would produce not only the expected pharmacodynamic interaction, but also whatever additional central depressant effect would be produced by the elevated steady-state plasma concentrations of alprazolam due to its impaired clearance.

Caution should also be observed when propoxyphene is prescribed for patients who use alcohol to excess.

References

1. Abernethy DR, Greenblatt DJ, Shader RI: Data on file, Wyeth Laboratories.
2. Patwardhan RV, Yarborough GW, Desmond PV, et al: Gastroenterology 79:912-916, 1980.
3. Abernethy DR, Greenblatt DJ, Divoll M, et al: Psychopharmacology 80:275-278, 1983.
4. Abernethy DR, Greenblatt DJ, Divoll M, et al: N Engl J Med 306:791-792, 1982.
5. Ochs HR, Greenblatt DJ, Abernethy DR: Data on file, Wyeth Laboratories.

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Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

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High Risk

(Continued from page 18)

effect of thromboxane for 24 hours and may not interfere with prostacyclin synthesis. It is recommended that hyperlipidemic patients who are not allergic to aspirin, take no more than one "baby aspirin" (75 mg tablet) each day.[4, 5]

Summary

The accumulating evidence of a direct association between serum lipid levels and degree of arteriosclerotic buildup indicates the need for a more rigorous approach to correction of abnormal lipid levels. High risk individuals can be identified by adequate documentation of abnormal serum lipid levels and early arteriosclerotic cardiovascular morbidity or mortality in first-degree relatives. Pharmacological and other means of intervention make it possible to correct abnormal serum lipoprotein levels in an attempt to inhibit the development of arteriosclerosis in individuals shown to be a high risk. The approach involves: performance of adequate screening tests; investigation of potential etiological and iatrogenic factors; and systematic evaluation of the effects of dietary, physical exercise, and pharmacological interventions.

References

1. Lipid Metabolism-Atherogenesis Branch, National Heart, Lung and Blood Institute: The lipid research clinics coronary primary prevention trial results. *JAMA* 251:365, 1984.

2. Connor WE, Connor SL: The dietary treatment of hyperlipidemia. *Med Clin North Am* 66:485, 1982.

3. Levy RI: Drugs used in the treatment of hyperlipoproteinemias. *The Pharmacological Basis of Therapeutics,* 6th edition (Gilman *et al* eds). New York, Macmillan, pp 834-847, 1980.

4. Weksler B *et al:* Differential inhibition by aspirin of vascular and platelet prostaglandin systhesis in atherosclerotic patients. *N Engl J Med* 308:800, 1983.

5. Scheidt SS: Antiplatelet therapy in ischemic heart disease. *Cardiovasc Rev Rep* 2:937, 1981.

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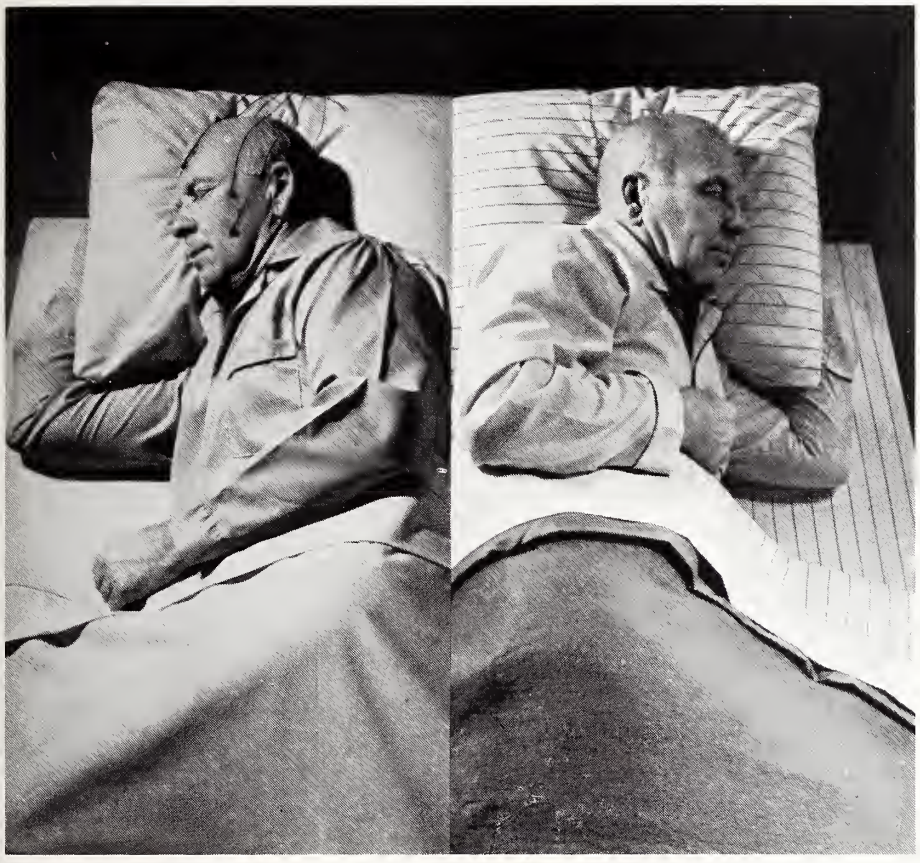
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COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF



FOR THE PREDICTABILITY CONFIRMED BY EXPERIENCE

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THE COMPLETE HYPNOTIC PROVIDES ALL THESE BENEFITS:

- Rapid sleep onset[1-6]
- More total sleep time[1-6]
- Undiminished efficacy for at least 28 consecutive nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids causing early awakenings or rebound insomnia after discontinuation of therapy[2,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

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References: 1. Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al. Pharmacology 26*:121-137, 1983.

DALMANE® Ⓝ
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

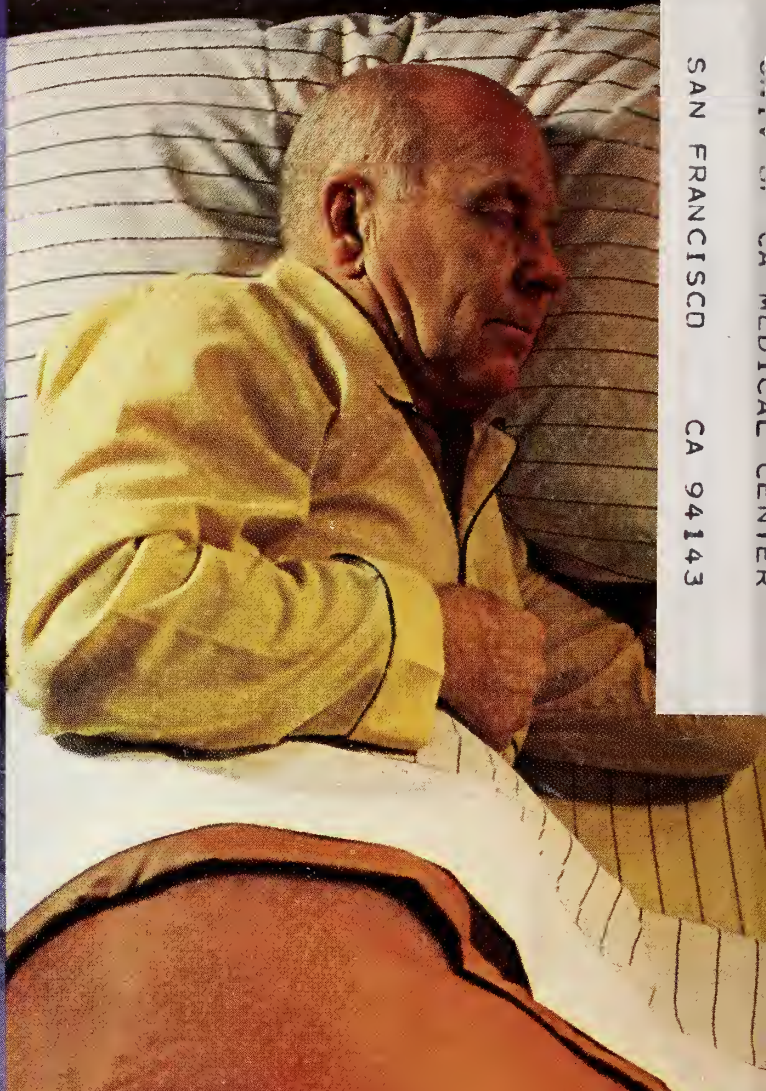
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DOCUMENTED IN THE SLEEP LABORATORY[1-5]...

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15-MG/30-MG CAPSULES



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KANSAS MEDICINE

VOLUME LXXXVI, Number 2, FEBRUARY 1985 ISSN 8755-0059



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KANSAS MEDICINE

• The Journal Of The Kansas Medical Society •

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THE BROADMOOR

New study reveals no interaction betwee



Ativan® (lorazepam) and Darvon® (propoxyphene HCl) Ⓒ Ⓘ

In a study evaluating the influence of propoxyphene coadministration on the pharmacokinetics of the oxidatively metabolized benzodiazepines Xanax® (alprazolam) Ⓒ and Valium® (diazepam) Ⓒ, and a benzodiazepine metabolized by conjugation, Ativan® (lorazepam), the following results were reported:

with Xanax, propoxyphene caused a large and highly significant prolongation of half-life and impairment of total metabolic clearance.[1]

in the case of Valium, propoxyphene produced a small but not statistically significant impairment of clearance.[1]

propoxyphene had no apparent effect on the distribution, half-life or clearance of Ativan.[1]

In this randomized crossover study, eight healthy male and female volunteers received single oral doses of alprazolam (1 mg), six received single IV doses of diazepam (10 mg), and five received single IV doses of lorazepam (2 mg), once in a drug-free control state and again during coadministration of propoxyphene (65 mg q6h). Consistent with previous findings, this study evidences that Ativan does not interact with drugs that undergo oxidative metabolism.[2-5] In contrast to most other benzodiazepines, Ativan does not compete for the cytochrome P-450 enzyme system.

The clinical implications of the pharmacokinetic interaction, or non-interaction, of propoxyphene with benzodiazepines are not established by this study. Even without a pharmacokinetic interaction, propoxyphene and benzodiazepines share central depressant properties and therefore should be coadministered with suitable caution. A concurrent pharmacokinetic interaction indicates a need for even further caution. Coadministration of propoxyphene and alprazolam, for example, would produce not only the expected pharmacodynamic interaction, but also whatever additional central depressant effect would be produced by the elevated steady-state plasma concentrations of alprazolam due to its impaired clearance.

Caution should also be observed when propoxyphene is prescribed for patients who use alcohol to excess.

References

1. Abernethy DR, Greenblatt DJ, Shader RI: Data on file, Wyeth Laboratories.
2. Patwardhan RV, Yarborough GW, Desmond PV, et al: Gastroenterology 79:912-916, 1980.
3. Abernethy DR, Greenblatt DJ, Divoll M, et al: Psychopharmacology 80:275-278, 1983.
4. Abernethy DR, Greenblatt DJ, Divoll M, et al: N Engl J Med 306:791-792, 1982.
5. Ochs HR, Greenblatt DJ, Abernethy DR: Data on file, Wyeth Laboratories.

Wyeth Laboratories
Philadelphia, PA 19101

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Ativan® for (lorazepam) Ⓒ Ⓘ Anxiety

See important information on following page.



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DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (IV)
for (lorazepam)
Anxiety

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

HOW SUPPLIED: 0.5, 1.0 and 2.0mg tablets.

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Philadelphia, PA 19101

IMPAIRED PHYSICIAN PROGRAM DIRECTORY

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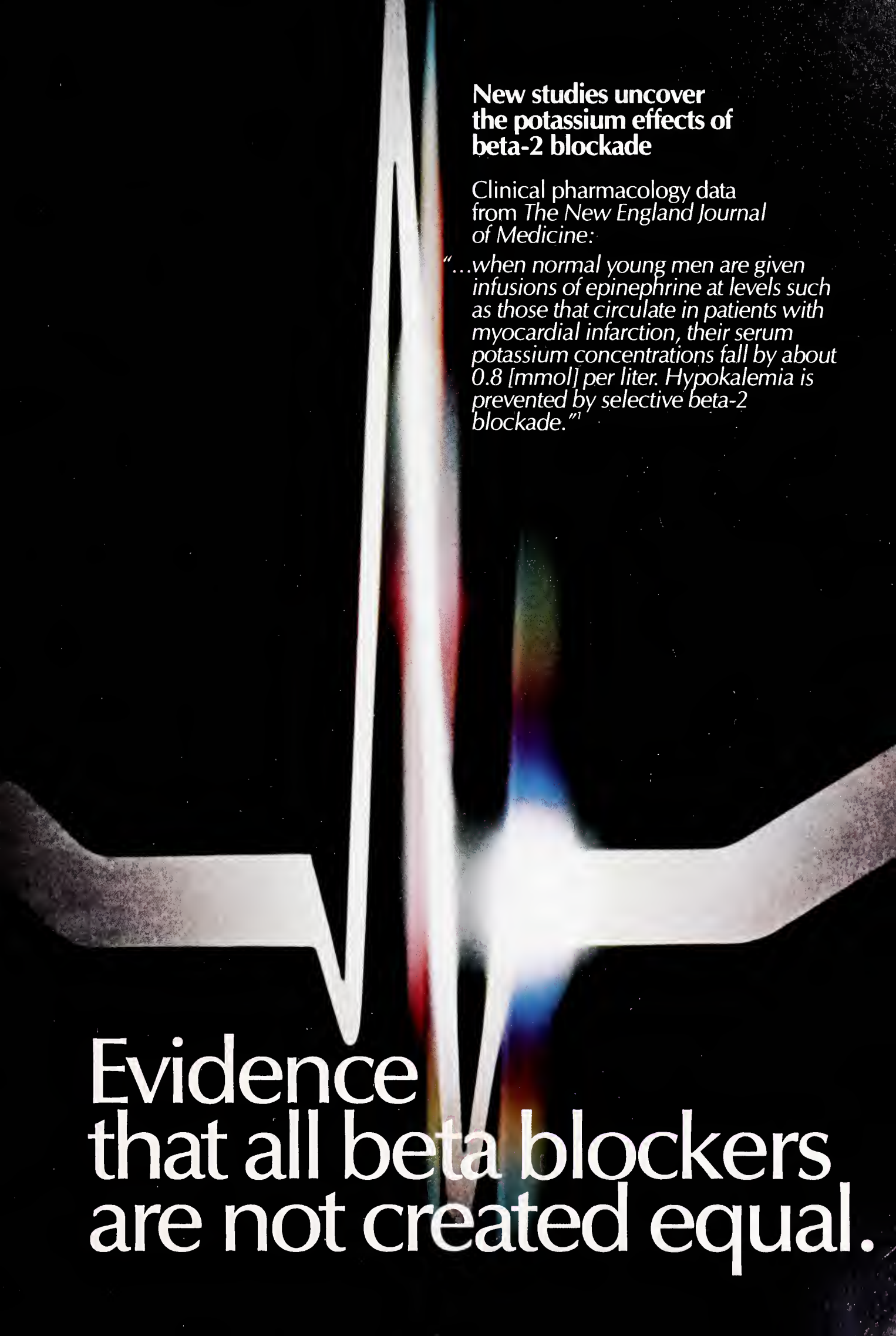
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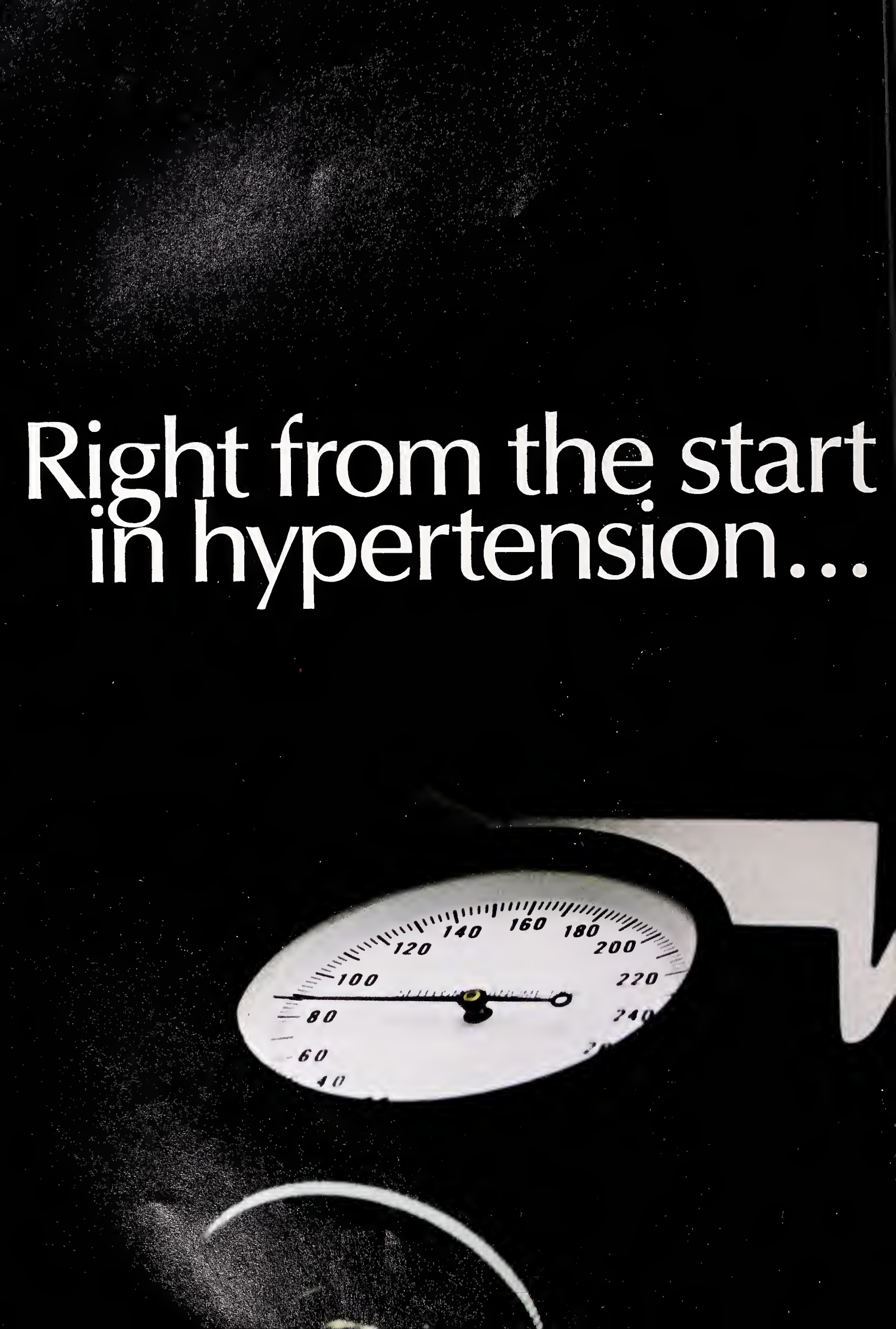
New studies uncover the potassium effects of beta-2 blockade

Clinical pharmacology data from *The New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 [mmol] per liter. Hypokalemia is prevented by selective beta-2 blockade."[1]

Evidence that all beta blockers are not created equal.

Right from the start in hypertension...





Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[2,3] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Please see brief summary of prescribing information on the next page for further details.

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of b receptor agonists and its effects can be reversed by administration of such agents, e dobutamine or isoproterenol. However, such patients may be subject to protracted se hypotension. Difficulty in starting and maintaining the heartbeat has also been reported beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the pearance of certain premonitory signs and symptoms (pulse rate and pressure change acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroid Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of sympt of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function te

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have b reported in which, after propranolol, the tachycardia was replaced by a severe bradyca requiring a demand pacemaker. In one case this resulted after an initial dose of 5 propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impa hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatmer hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Pati should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dise elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as re pine should be closely observed if INDERAL is administered. The added catecholam blocking action may produce an excessive reduction of resting sympathetic nervous act which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthos hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals h been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studie both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signifi drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dos levels. Reproductive studies in animals did not show any impairment of fertility that attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotox animal studies at doses about 10 times greater than the maximum recommended human d

There are no adequate and well-controlled studies in pregnant women. INDERAL sh be used during pregnancy only if the potential benefit justifies the potential risk to the fe

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised w INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and h rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hy tension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insom lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; vi disturbances; hallucinations; an acute reversible syndrome characterized by disorientatio time and place, short-term memory loss, emotional lability, slightly clouded sensorium, decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrh constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with ach and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytope purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has b reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male im tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous react involving the skin, serous membranes and conjunctivae reported for a beta blocker (pract have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride sustained-release capsule for administration once daily. If patients are switched from INDE tablets to INDERAL LA capsules, care should be taken to assure that the desired therape effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration be necessary especially to maintain effectiveness at the end of the 24-hour dosing inte

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may increased to 120 mg once daily or higher until adequate blood pressure control is achie The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of mg may be required. The time needed for full hypertensive response to a given dosag variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL once daily, dosage should be gradually increased at three to seven day intervals until optim response is obtained. Although individual patients may respond at any dosage level, average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few we (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL once daily. The usual effective dose range is 160-240 mg once daily. The dosage may increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is obtained within four to six weeks after reaching the maximum dose, INDERAL LA the should be discontinued. It may be advisable to withdraw the drug gradually over a perio several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are limited to permit adequate directions for use.
REFERENCES
1. Epstein FH, Rosa RM: Adrenergic control of serum potassium. *N Engl J Med* 19 309:1450-1451. **2.** Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ecto activity. *Am J Med* 1981;70:762-768. **3.** Holme I, Helgeland A, Hjermann I, et al: Treatmer mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study an MRFIT. *JAMA* 1984;251:1298-1299.

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AMERICAN MEDICAL ASSOCIATION

Principles of MEDICAL ETHICS

Preamble:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

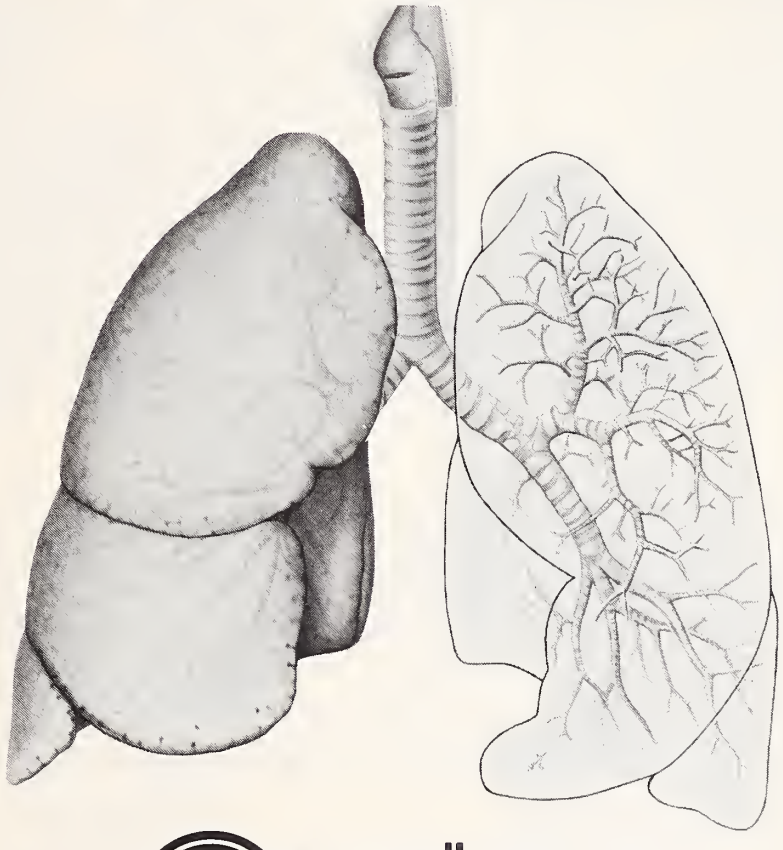
V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

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Brief Summary: Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbiliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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VOX DOX

Vox Dox Editor:

A National Institutes of Health (NIH) Consensus Panel has issued a report entitled "Fresh Frozen Plasma: Indications and Risks." This report is now available from the NIH.

The report was prepared by a panel of experts, which considered scientific evidence presented at a consensus development conference at the NIH. It contains recommendations and conclusions concerning fresh frozen plasma.

At NIH, consensus conferences bring together researchers, practicing physicians, representatives of public interest groups, consumers, and others to conduct scientific assessments of drugs, devices, and procedures in an effort to evaluate their safety and effectiveness.

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DWI

The November 1984 issue of the *Newsletter* of the Medical Society of New Jersey reports the following penalties for drunk driving in other countries:

Australia . . . The names of the drivers are sent to the local newspapers and are printed under the heading "He's drunk and in jail."

Malaya . . . The driver is jailed, and if he's married, his wife is jailed too.

South Africa . . . A 10-year prison sentence and the equivalent of a $10,000 fine or both.

Turkey . . . Drunk drivers are taken 20 miles from town by the police and forced to walk back, under escort.

Norway . . . Three weeks in jail at hard labor, one year loss of license. Second offense within five years — license revoked for life.

Finland and Switzerland . . . Automatic jail for one year at hard labor.

Costa Rica . . . Police remove plates from car.

Russia . . . License revoked for life.

England . . . One year license suspension, $250 fine, and jail for one year.

France . . . Three year loss of license, one year in jail, and $1,000 fine.

Poland . . . Jail and fine, and forced to attend political lectures.

Bulgaria . . . A second conviction results in execution.

El Salvador . . . Your first offense is your last. Execution by firing squad.

Professional Liability Survey

Kansas Medical Society, October 1984

In October 1984, the Kansas Medical Society surveyed its member physicians for data and opinions on the medical professional liability environment in Kansas. In all, 1,261 responses were received, which represents about one-half of the active, practicing membership. The responses were classified by specialty area of practice.

Results of the survey showed a considerable degree of concern among Kansas physicians about the professional liability situation. Nearly nine of ten physicians (86%) said problems associated with medical malpractice have affected their practices. Many felt the physician-patient relationship had suffered because of medical malpractice problems. Physicians apparently are delegating less responsibility to assistants (42%), and more than one-half (51%) are limiting their practices to less risky procedures.

The phenomenon of defensive medicine is very much an outcome of professional liability pressure. More than three-fourths (76%) of physicians who responded to the survey are prescribing additional diagnostic tests; and two-thirds (66%) use consultants more frequently.

Data on frequency of claims in Kansas seem to parallel national trends. Almost 40 per cent of Kansas physicians have been sued during their careers. Of those who have been sued, two-thirds (66%) have been sued once, one-third had two to four suits, and fewer than 1 per cent had five or more claims. These data dispel the myth that it is only the "bad doctor" who gets sued. Frequency of suits varies by specialty, with physicians in higher risk practices having greater claim activity.

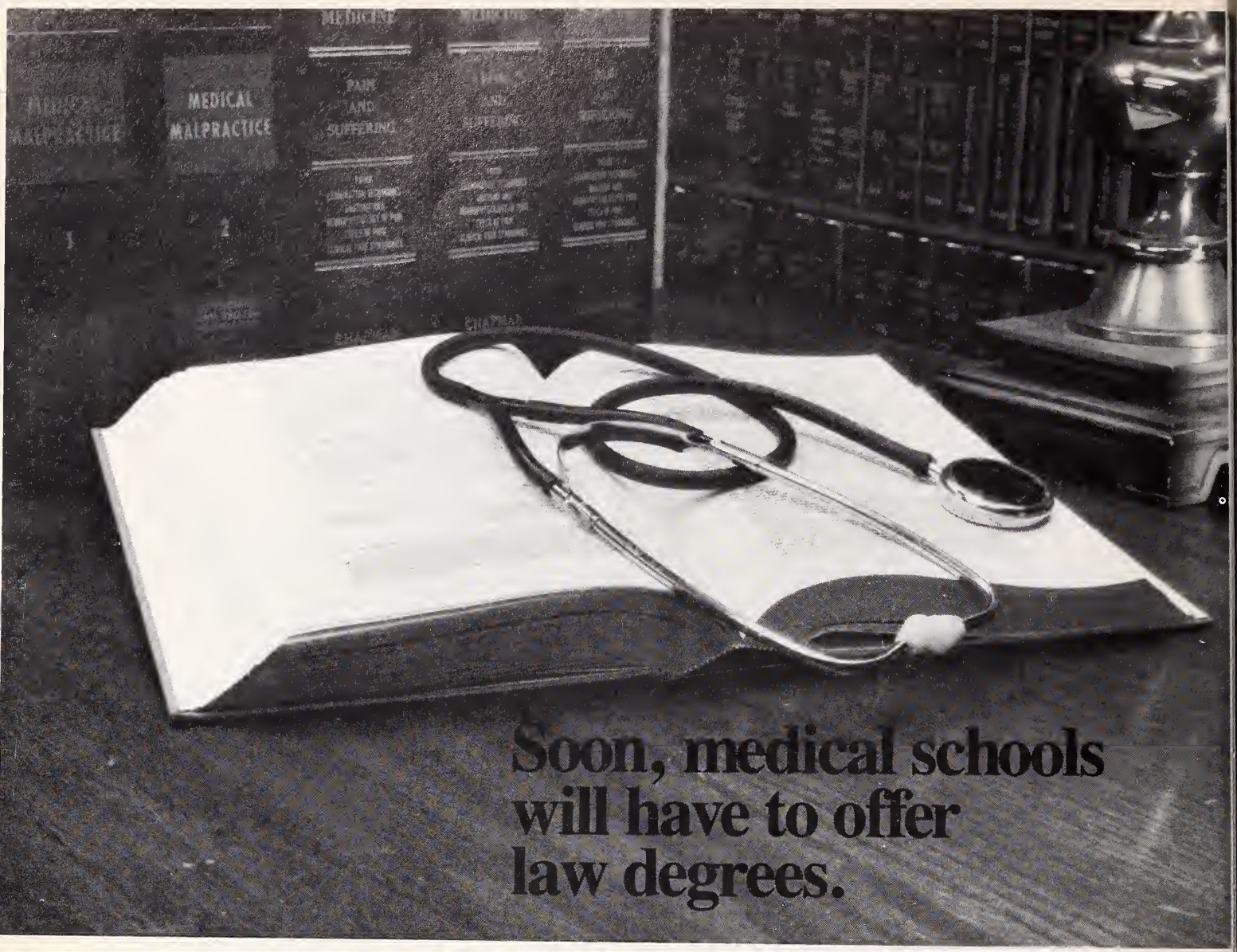
Respondents whose practices have included obstetrics were asked to answer a specific set of questions to determine if the professional liability situation might be creating problems of access to obstetrical care. The results provide a bleak picture of what lies ahead in this high risk field of practice. About three of ten physicians (28%) who had practiced obstetrics had stopped altogether. Another one-third indicated they planned to discontinue obstetrics practice in the near future if the liability situation didn't improve. Taken together, 61 per cent of the respondents had either quit obstetrics practice or were planning to quit in the near future. Significantly, a large number of those who plan to discontinue obstetrics practice are family practitioners, presumably many in rural areas. The responses to this particular question clearly indicate potential access problems for obstetrical patients in many Kansas communities.

The respondents were also asked for the names of their insurance carriers. Medical Protective insured the most physicians at 40 per cent of the market. St. Paul Fire and Marine was close at 35 per cent of the market. Two relative newcomers to the state — Pennsylvania Casualty and Medical Defense — had 9 and 6 per cent of the market, respectively.

About 3 per cent of respondents were insured through the state insurance availability plan administered by Western Casualty of Fort Scott. The remaining 7 per cent were spread among several smaller insurers, mostly specialty-related carriers.

In summary, the 1984 survey showed serious concerns among Kansas physicians about problems associated with medical professional liability. A significant number of physicians surveyed indicated the professional liability situation is adversely affecting their practices and contributing to early retirement decisions. Physicians who practice obstetrics are especially concerned about the future, and problems of access to care may not be far away. Widespread defensive medicine and a more conservative practice approach are significant trends among Kansas physicians. Overall, the survey indicates that problems associated with professional liability are escalating rapidly, and that physicians are extremely concerned about the future of patient care in such an environment.

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SCIENTIFIC ARTICLES

Carotid Occlusion and Pseudo-Occlusion

ALEX D. AMMAR, M.D.,* *Wichita*

ARTERIOGRAPHIC SUBTLETIES of differentiating internal carotid artery (ICA) occlusion from severe stenosis have been the subject of comment by many clinicians and radiologists in the past.[1-8] Although the arteriographic separation between preocclusion and total occlusion is most often simple, a few arteriograms are misleading in that they demonstrate radiographic occlusion when the artery is anatomically patent. This differentiation was essential because of the early poor results following carotid endarterectomies in chronically occluded ICAs which led many clinicians to abandon surgical intervention in these circumstances.[9] The separation remains crucial, owing to the fact that the stroke rate of severely stenotic (preocclusive) ICAs which are allowed to completely occlude is as high as 40 per cent;[10] however, circumstances presently exist whereby surgical treatment should be recommended in some patients even if these arteries are totally occluded.[2, 4, 11-17]

We have recently seen three transiently symptomatic patients with apparent arteriographic evidence of ICA occlusion in whom, with careful scrutiny, we clinically and radiographically suspected the carotids might be patent. Based on this experience, we became interested in redefining the arteriographic criteria of differentiating ICA occlusion from pseudo-occlusion and in restating the situations in which surgical intervention should be recommended.

Methods

During the past seven months, in a large community hospital, 148 cervicocephalic arteriograms (either intravenous or intraarterial digital subtraction arteriograms [DSA], or conventional arteriograms) were evaluated by the author. Of these, three patients were seen with suspected arteriographic evidence of ICA occlusion. DSA and conventional arteriography were performed by the standard techniques with selective injections (conventional), multiple views, subtraction filming, and delayed filming. All films were read by highly skilled, board certified radiologists. All three patients were symptomatic with respect to the suspected occluded artery. These three patients were operated under general anesthesia. Carotid exploration or endarterectomy was performed in the standard fashion. The need for intraluminal shunting was based on the ICA stump pressure of less than 50 mm of mercury or in the presence of a previous cerebrovascular accident or contralateral ICA occlusion.

Case Histories and Comments

Case One: A 79-year-old white male presented on September 28, 1982 with one episode of amaurosis fugax to the right eye. An intravenous DSA of excellent quality performed two days later demonstrated a suspected occlusion of the right ICA and a severe stenosis of the left ICA *(Figure 1)*. There was a 1.0 cm stump of widely patent right ICA proximal to the occlusion. Late films did not show filling of the intracranial ICA. Because of this man's symptom and the relatively long stump of proximal ICA, however, we felt that the carotid might possibly be patent anatomically.

We saw this patient on October 4, and he underwent a successful left carotid endarterectomy the following day. Thirty-six hours after operation the patient experienced another episode of right amaurosis fugax. On October 8, the right carotid artery was explored and, as the angiographer predicted, the ICA was occluded with old thrombus. There was mild stenosis without ulceration in the external carotid artery (ECA). The ECA was endarterectomized and the stump of the ICA was oversewn. The patient suffered no complications and was dismissed on the second postoperative day. He has been asymptomatic since that time (20 months).

Comment: This case demonstrates a relatively long stump of patent ICA proximal to the occlusion.

* Clinical Assistant Professor, Department of Surgery, UKSM-Wichita.

From The University of Kansas School of Medicine-Wichita.

Address reprint requests to Dr. Ammar, 818 No. Emporia, Suite 200, Wichita KS 67214.



Figure 1. Intravenous DSA (left posterior oblique) showing long, widely patent stump of right ICA (arrow) with sudden blunt cut-off. The left ICA stenosis was shown in another view (not pictured).

As is widely known, arteries without branches, in general, occlude back to their origin or to within 1 cm of their origin. This, of course, is the anatomic situation in the extracranial ICA. Although the arteriogram in this case did reveal a relatively long stump of ICA, this stump demonstrates a sudden and blunted cut-off as opposed to the long, tapered cut-off seen with some preocclusive lesions.[1, 3] The absence of visualization of the intracranial ICA is another clue suggesting that the artery is totally occluded.

Many possibilities exist to explain this patient's symptom of right amaurosis fugax. Initially, we felt that the amaurosis might be related to hypoperfusion from the significantly stenotic contralateral left ICA. However, since the symptom recurred 36 hours after a left carotid endarterectomy, the right amaurosis fugax was more likely due to microembolization through collaterals off the ipsilateral right ECA.[13] These emboli most probably arose from the occluded stump of the right ICA[11] since the right ECA was only mildly stenosed and was not ulcerated. Hypoperfusion through the ipsilateral ECA collaterals is not a possibility since, again, the stenosis in the right ECA was insignificant. Thus, surgery was performed in this patient to eliminate further embolization. He has remained asymptomatic from the time of his last operation.

Case Two: An 84-year-old white female presented with left hemispheric transient ischemic attacks manifested by right arm and hand numbness and weakness. Intravenous DSA performed March 17, 1983 was reported to demonstrate complete occlusion of the left ICA *(Figure 2a)*. Nonetheless, careful scrutiny of the AP films showed that this patient seemed to possess a preocclusive lesion at the origin of the left ICA with filling of the distal extracranial ICA (*Figure 2b)*. Since we were asked to see this woman several days after the DSA was done, we requested a conventional arch and selec-

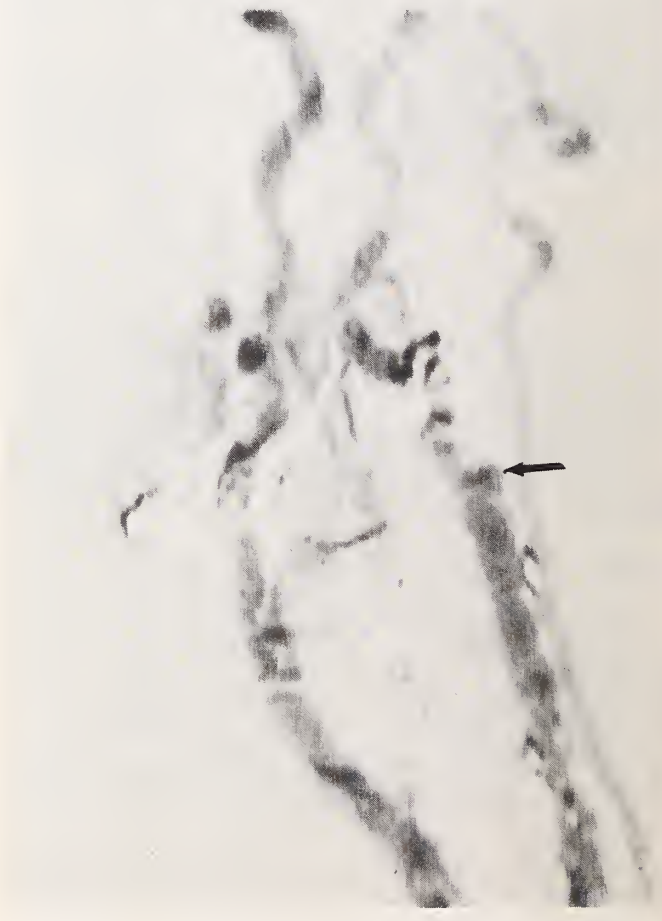


Figure 2a. Intravenous DSA (right posterior oblique) demonstrating apparent occlusion of the left ICA (arrow).



Figure 2b. Same study but different view (anteroposterior) demonstrating preocclusive lesion at origin of left ICA (arrow).



Figure 2c. Conventional arch aortogram (same view as *2a)* again showing apparent left ICA occlusion (arrow).

tive left carotid arteriogram to determine if the artery remained patent. The left carotid could not be selectively catheterized so only the arch study was done. Again, it was read by the radiologist as total left ICA occlusion on the one view obtained *(Figure 2c).*

Surgery was performed on March 29, and the left ICA was found to be patent with a preocclusive lesion at its origin. A left carotid endarterectomy was completed. The patient had no neurological complications and was dismissed on the third postoperative day. She has remained asymptomatic to date (14 months).

Comment: This case demonstrates the absolute necessity of at least biplane arteriography.[6] Here, one view on the DSA revealed the left ICA to be occluded, whereas another view showed it to be patent. Because the angiographer may have been initially biased regarding his notion that the left ICA was occluded on the DSA, only one view was obtained on the arch aortogram and this also shows an apparent left ICA occlusion. Furthermore, a selective left carotid injection could not be performed due to technical factors and this added to the confusion. Nonetheless, careful inspection of the arteriograms led to the correct diagnosis and treatment, with the patient continuing to be asymptomatic.

Case Three: A 67-year-old white male experienced right amaurosis fugax on April 3, 1983. On April 4, he underwent an intravenous DSA which revealed a suspected occlusion of the right ICA as read by the angiographer; however, further analysis showed there was a tiny column of dye progressing distally *(Figure 3a).* We saw this man on April 12, and a conventional arteriogram was performed. This revealed a clot at the origin of the right ICA *(Figure 3b)* with a pinpoint lumen distally *(Figure 3c).* In addition, this patient had no history of cardiac disease, and the EKG, echocardiogram, and 24-hour Holter monitor results were normal.

The patient was taken to the operating room on April 13, where the right carotid artery was opened. He was found to have a recently formed clot at the origin of the right ICA but no tail clot or thrombus extended distally. There was significant occlusive disease at the carotid bifurcation with severe stenosis, ulceration, and plaque hemorrhage. A right carotid endarterectomy was accomplished. He suf-



Figure 3a. Intravenous DSA (left posterior oblique) revealing apparent occlusion of right ICA with long, tapered cut-off (lower arrow). Careful observation shows faint dye in distal extracranial ICA (upper arrow).



Figure 3b. Conventional selective right carotid arteriogram (left posterior oblique) showing clot at origin of ICA; arrows point to medial and lateral walls of ICA.

fered no neurological complications postoperatively and was dismissed on the third postoperative day. The patient has been without symptoms to this time (13 months).

Comment: This case again exemplifies the potential hazard of careless glancing at carotid arteriograms. On initial observation the right ICA was thought to be occluded; however, further studies showed a tiny column of dye progressing distally. Two factors contribute to the appearance of pseudo-occlusion in cases of extreme carotid stenosis.[1-5, 7, 8] One factor is partial collapse of the arterial lumen distal to a critical lesion supposedly due to reduction in intravascular pressure. The second factor is the slowly flowing dense dye which layers along the most dependent portion of the artery, further exaggerating the appearance of collapse of the distal artery. This phenomenon has been labeled "poststenotic carotid slim sign."[5] In addition, the amount of contrast material progressing beyond a preocclusive lesion may be inadequate to arteriographically visualize by present methods, especially if extreme care is not exercised in obtaining multiple views, subtraction films, magnification, delayed films, and selective injections. In this regard, rapid sequential computerized tomographic scanning[18] may help separate those patients with total occlusion from those with extreme stenosis. Lastly, the carotid bulb is known to change diameter during each cardiac cycle[19] so that if the arteriogram is taken during diastole, a severe lesion may appear totally occluded when it is actually patent anatomically. Therefore, with the above knowledge and with careful inspection of the arteriogram, this patient was offered optimal treatment (carotid endarterectomy) and has been without symptoms to the time of this writing.

Conclusion

Several important points regarding the diagnosis and treatment of carotid artery occlusive disease are exhibited by the case histories described. Not only are many arteriographic features demonstrated, but also many pathophysiologic and surgical considerations are exemplified. The arteriographic criteria of distinguishing ICA occlusion from pseudo-occlusion deserve reiteration. The clinician, angiographer, and vascular surgeon must be aware of many arteriographic subtleties including the long, tapered ICA stump in symptomatic patients with suspected



Figure 3c. Conventional selective right carotid arteriogram (lateral view) demonstrating proximal ICA (lower arrow) and pinpoint distal lumen (upper arrow).

carotid occlusion; possible patency of the intracranial vasculature; the possibility of inadequate concentration of dye and consequent lack of visualization beyond a critical lesion; the layering and collapse phenomenon (''carotid slim sign''); the necessity for multiple arteriographic views, subtraction filming, selective catheterization, and delayed filming. Moreover, one must be aware of the significant risk of stroke in patients who are left unoperated because the arteriogram is misread as ICA occlusion when, in actuality, a preocclusive lesion is present and subsequently allowed to occlude. In a patient with transient symptoms, it is safer to underread rather than overread carotid occlusion. Thus, only when this information is recognized will the true status of the ICA be determined and will patients with cerebrovascular disease be treated appropriately.

In addition to the arteriographic points listed above, the surgical considerations should be reemphasized. Exploration of a carotid artery in the transiently symptomatic patient in which the arteriographic data is equivocal carries a low risk. If a preocclusive lesion is found at operation or if the distal ICA is patent with cervical ICA occlusion,[1-4, 7, 8, 15, 16] routine carotid endarterectomy may be performed. If the carotid artery is, in fact, totally occluded, a diseased ECA can be endarterectomized in order to eliminate embolization, to increase collateral flow to the ipsilateral cerebral hemisphere,[17] and also to possibly render the patient a better candidate for future EC/IC bypass if it becomes necessary.[14] In addition, the ICA stump can be oversewn to eliminate further embolization from this source through the ECA and its collaterals. These surgical points should be carefully considered in patients with transient symptoms. Surgery is not recommended for all chronic carotid occlusions, but more careful scrutiny of these cases is warranted, especially in symptomatic patients and in patients with equivocal arteriograms.

References

1 Clark OH *et al.:* Radiographicaliy occluded, anatomically patent carotid arteries. *Arch Surg* 102:604-606, 1971.

2. Countee RW, Vijayanathan T: Reconstitution of ''totally'' occluded internal carotid arteries — angiographic and technical considerations. *J Neurosurg* 50:747-757, 1979.

4. Heros RC, Sekhar LN: Diagnostic and therapeutic alternatives in patients with symptom ''carotid occlusion'' referred for extracranial-intracranial bypass surgery. *J Neurosurg* 54:790-796, 1981.

5. Lippman HH *et al.:* The poststenotic carotid slim sign: Spurious internal carotid hypoplasia. *Mayo Clin Proc* 45:762-767, 1970.

6. Newton TH, Couch RSC: Possible errors in the arteriographic diagnosis of internal carotid artery occlusion. *Radiology* 75:766-773, 1960.

7. Sekhar LN *et al.:* Atheromatous pseudo-occlusion of the internal carotid artery. *J Neurosurg* 52:782-789, 1980.

8. Yonas H, Meyer J: Extreme pseudo-occlusion of the internal carotid artery. *Neurosurg* 11:681-686, 1982.

10. Grillo P, Patterson RH Jr: Occlusion of the carotid artery: Prognosis (natural history) and the possibilities of surgical revascularization. *Stroke* 6:17-20, 1975.

11. Barnett HJM *et al.:* ''Stump'' of the internal carotid artery — a source for further cerebral embolic ischemia. *Stroke* 9:448-456, 1978.

14. Hertzer NR: External carotid endarterectomy. *Surg Gynecol Obstet* 153:186-190, 1981.

Other references are available on request from Dr. Ammar, 818 No. Emporia, Suite 200, Wichita KS 67214.

Amitriptyline Overdose

R. E. COHNBERG, M.D.; PHYLLIS MACY-MILLS, P.A.-C.; ELIZABETH JOHNSON, P.A.-C. *and* **DONALD D. STONER, A.T.P.,** ***Cedar Vale***

A DEATH from amitriptyline overdose was reported recently from Albert Einstein College of Medicine.[1] Cardiologists Ralph Silverman, M.D. and Neal Fromenbaum, M.D. reported that the 41-year-old patient had a blood level of amitriptyline greater than 1,000 ng/ml. Treatment of their patient differed somewhat from the treatment used here, and it is hoped that this report of our success may be of use to others who are faced with the same problem.

Case Report

A 48-year-old white female, who had previously been in reasonably good health, had been seen occasionally in our clinic for minor physical complaints. Her history included psychiatric treatment for numerous suicide attempts. Her most recent visit to the psychiatrist had been two years prior to the present episode. However, because of increasing depression, she had called the psychiatrist who authorized refills of diazepam and amitriptyline prescriptions three months before this episode and then again two months later. We were unaware of the increasing depression and the prescriptions.

At 5:55 p.m. on August 22, 1984, an ambulance was called to the patient's home. Family members stated that the patient had "taken pills" and had been drinking for some time, and they were unable to arouse her. The ambulance crew arrived at 5:59 and found the patient slumped in a chair, totally unresponsive to verbal and painful stimuli. Her breathing was shallow and irregular, her skin was pale, and her heart sounds were distant and rapid. Her eyes showed mid-sized pupils which were unresponsive to light and to accommodation. Her blood pressure at the scene was 82/40, her respiratory rate was 16, and her pulse was weak and thready, irregular and rapid. An intravenous solution of 5 per cent dextrose in lactated Ringer's solution was started immediately. An airway was placed with oxygen at 15 l/min and the patient was then transported to the hospital.

On arrival at the emergency room at 6:10 p.m. the patient underwent gastric lavage; the gastric contents, a urine specimen obtained by Foley catheter, and blood specimens were sent to St. Francis Hospital in Wichita for drug screening. A nasogastric tube was placed and attached to constant low suction.

The patient had aspirated some mucous, and her nose and trachea were suctioned and she was placed on a cardiac monitor. Her EKG pattern showed a first degree AV block and her pulse was 130 beats/min with numerous PVCs. Ten minutes after admission her pulse increased to 168 beats/min. Naloxone (Narcan) was given followed one minute later with two additional ampules intravenously. This was followed with ascorbic acid, 1 gm, intravenously. (The ascorbic acid was used to reverse the effects of alcohol. It is used routinely here for alcoholics who require detoxification.) At 6:30 the patient's blood pressure was 160/90 and she remained unresponsive. A fourth ampule of naloxone was given intravenously followed by a fifth at 6:48 p.m., and blood pressure at that time was 140/84. Approximately 15 minutes later, because of continuing atropine-like symptoms, edrophonium (Tensilon), one ampule, was administered intravenously. Blood pressure was 120/80 at this time. Thiamine chloride, 100 mg, was given slowly intravenously at 7:04 p.m. The patient remained unresponsive to verbal and painful stimuli. However, her breathing was adequate so intubation was not necessary.

The patient was taken to the Intensive Care Unit. Vital signs at 7:10 p.m. were: pulse, 100; respiration, 20; and blood pressure, 120/82.

After admission to the ICU, the patient was started on cefotaxime sodium (Claforan) because of the aspiration. She also was started on intermittent positive pressure breathing administered for about 2.5 hrs.

The patient's blood pressure began to fall, and she was treated with two units of plasmanate. The intravenous fluids were changed from 5 per cent dextrose in lactated Ringer's solution to normal saline with potassium supplement for mild hypokalemia. Calcium gluconate, 10 cc, was given slowly intravenously for mild hypocalcemia.

About 1.5 hrs later, the patient again required plasmanate. At 10:15 p.m., the patient began to show some response to painful stimuli, and at 11:30 p.m. her response became stronger. At 2:23 a.m.,

From the Cedar Vale Regional Hospital and Clinic.
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she responded to verbal stimuli, and by the next morning, she was talking. That afternoon the nasogastric tube was removed and the patient was started on food and oral medications. Suicide precautions were maintained.

During the examination and treatment in the emergency room, a call was made to the patient's psychiatrist who confirmed a history of depression and the history of the prescription refills.

Because of continued tachycardia, which we felt was amitriptyline induced, we started her on propranolol (Inderal), 20 mg tid, on August 26. The tachycardia soon abated, and the next day she was discharged to psychiatric followup in the custody of relatives.

Discussion

A limited history was available from the patient's family. They did not know how many or what kind of pills she had taken, but were aware that the psychiatrist had authorized refills of two prescriptions which proved to be diazepam (Valium) and amitriptyline (Elavil). They also did not know how much alcohol the patient had consumed, but were certain that it had been at least a six-pack of beer during the afternoon of this apparent suicide attempt. They also knew that the patient had appeared normal at about 5:00 p.m.

The report from the reference laboratory was received ten hours after her admission to the hospital. It showed the blood level for amitriptyline was 940 ng/ml, which was at the very upper limits of the detectable range by the method used. Therapeutic levels are considered between 125 and 250 ng/ml. The blood specimen also showed a nortriptyline level of 262 ng/ml with therapeutic levels between 50 and 150 ng/ml. The blood alcohol level was 0.105 per cent, which is above the level for legal intoxication. Both urine and gastric contents were positive for amitriptyline, nortriptyline, and other metabolites.

Treatment of this patient could not, of course, await the results of the tests. Apparently the patient had taken the medicine early enough for the drug and its metabolites to be found in the blood and urine.

During her first hour in the hospital, routine urine tests were negative except for the toxins mentioned above; CBC, liver tests, BUN, and creatinine were normal. Her electrolyte measurements showed mild hypokalemia and hypocalcemia.

Her admission EKG showed a first degree AV block and a slightly prolonged QRS as compared to a previous EKG. Her QT was essentially normal. By 9:00 a.m. of August 23 her QRS was back to normal width for her.

Basic management of any patient with this kind of history includes assurance of an open airway and maintenance of adequate respiration and blood pressure. The patient should be started on oxygen, and an intravenous line should be placed. Symptomatic treatment must be initiated immediately pending results of toxicology screens which will require at least eight to ten hours.

Because our patient was unconscious, we protected her airway but felt that an endotracheal tube was unnecessary. We were prepared to insert one if needed, however.

After the patient was lavaged, constant deflation of the abdomen through a nasogastric tube was indicated. Bowel sounds, as expected, were depressed — probably as a result of the amitriptyline, which has anticholinergic properties.

Because of this and other anticholinergic responses such as the increase in blood pressure and tachycardia, we used one ampule of edrophonium (Tensilon). This drug has a rapid onset of action and about a ten-minute length of life. We felt that use of this drug was fairly safe, but a rapid decrease in blood pressure alarmed us and we did not use it again.

Thiamine and vitamin C were administered intravenously because of the suspicion of intoxication. This regimen is used routinely to detoxify our alcoholic patients, and is almost invariably successful. Furthermore, since ascorbic acid has an oxydative-reductive capacity, we felt that it might help to detoxify the amitriptyline. We have no proof that it can and no proof that it did.

EKG changes raised a concern about major arrhythmias. Frequent PVCs were observable early in the patient's hospitalization. These cardiac problems are typical of amitriptyline toxicity, and careful attention to the cardiac abnormalities is always necessary. The edrophonium was used partly because of its effect on the cardiovascular system but the results were too dramatic to chance its repeat use.

Conclusion

A 48-year-old white female had consumed a toxic amount of amitriptyline and alcohol. Comparison of our therapy with that of Drs. Silverman and Fromenbaum reveals that the major difference was in the use of vitamin C, Tensilon, plasmanate to maintain blood pressure, and an increased dosage of naloxone. It is not known if the difference in out-

(Continued on page 62)

Pertussis Outbreak in SE Kansas — 1983-84

PAKIT VICHYANOND, M.D., *Parsons, and* LLOYD C. OLSON, M.D., *Kansas City, Missouri*

AN OUTBREAK of pertussis occurred during the winter of 1983-1984 in Southeastern Kansas. A large number of cases occurred in clusters in Labette and Neosho Counties. Described here are the epidemiology, clinical manifestations, and immunization status of pediatric patients with pertussis as encountered in the author's (P.V.) practice during this period.

Material and Methods

During March 1983 to May 1984, nasopharyngeal swabs were obtained from patients who manifested clinical symptoms resembling classical pertussis (persistent cough with/without vomiting and with/without whoops). Specimens were transported to the Central Laboratory of the Kansas Department of Health and Environment (Topeka) for direct fluorescent antibody (FA) examination for *Bordetella pertussis*. Medical records of patients with a positive FA test were reviewed. All but one of the patients reported here were examined and treated by the author (P.V.).

Results

From March 1983 to May 1984, specimens from 33 patients were positive by FA examination for pertussis. One patient with a negative specimen was included in the study since her symptoms were classical of pertussis and one month later her older brother developed a clinical syndrome with a positive FA test. Therefore 34 patients were classified as having pertussis. There were three pairs of siblings in these 34 cases. Medical records were available for review from 33 patients. (Immunization records and clinical response of one patient seen in the emergency room could not be completed despite many telephone attempts.)

Twenty-five cases (75%) were diagnosed during December 1983 and January 1984. Seven cases were seen from March to November 1983. Two cases occurred in the period from February to May 1984.

Age: The age range was from 24 days to 8 years with the mean of 26 months and the median of 18 months. *Table I* illustrates the distribution and percentage of cases in each age group.

Sex: There were 19 males and 15 females (male : female ratio was 1.26 : 1).

Clinical Presentation: Thirty-two patients presented with symptoms of acute upper respiratory tract infections (rhinorrhea and cough). Six cases (18%) presented with otitis media. Croup was the major symptom in three cases (9%). Acute bronchitis/bronchiolitis were diagnosed in seven cases (21%). Pneumonia was diagnosed either from clinical findings or a positive chest x-ray in ten patients (30%). Eight patients (24.2%) required hospitalization (age range 2 months to 7 years; median 4.5 months).

Pertussis Pneumonia: Ten patients were diagnosed either clinically or radiographically as having pertussis pneumonia. Their ages ranged from 1 month to 7 years with the median of 17.5 months. Eight patients had chest x-rays which were interpreted as abnormal. Five were admitted to the hospital. Of three infants below 2 years of age, two had severe wheezing. Common patterns of radiographical findings were hyperinflation (5/8), perihilar infiltration (5/8), and right lower lobe infiltration (3/8).

Bronchiolitis: Seven patients presented with the picture of bronchiolitis. Their ages ranged from less than 1 month to 5 months with the median of 4 months. Four children, ages 2-5 months, wheezed severely and required treatment in the hospital with bronchodilators. All cases resolved completely.

Presentation in Younger Infants: There were six patients who were less than 2 months of age. Three were classified as having mild disease (24 days, 1½

TABLE I
AGE OF PATIENTS WITH PERTUSSIS
(33 PATIENTS)

Age group	*# of cases (%)*	*Accumulated %*
0-1 mos	1 (3.03)	3.03
1-6 mos	10 (30.3)	33.33
6-12 mos	1 (3.03)	36.36
1-2 yrs	10 (30.3)	66.66
2-3 yrs	4 (12.12)	78.78
3-5 yrs	3 (9.1)	87.88
> 5 yrs	4 (12.12)	100
TOTAL	33 (100)	100

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KMS

Kansas Medical Society Newsletter

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PROFESSIONAL LIABILITY UPDATE

Professional Liability Update - Survey Results

As the Legislature begins taking a serious look at the KMS program for reform contained in SB-110, we thought the results of our surveys would be of interest to the membership. In October, 1984 we asked Kansas physicians how the professional liability situation had affected their practices. In addition to huge premium increases, several other effects were expressed by the more than 1,200 respondents. Significantly, many physicians, especially those doing obstetrics, indicated they would start limiting their practices if the situation didn't improve soon. The emotional and financial pressures of the runaway malpractice problems are taking their toll on Kansas physicians. Nearly nine of ten physicians said problems associated with medical malpractice have affected their practices in some way. For details of the survey, see Page 43 in this issue of Kansas Medicine.

We also surveyed the public in December, 1984 and found a very receptive climate for tort reform. A Wichita opinion research firm did the telephone surveys for KMS. Among the more significant findings was that a majority of Kansans (63%) would favor a reasonable limit on awards in medical malpractice lawsuits. This result validates several national opinion polls which indicate that people in this part of the country feel some reasonable restraints need to be imposed on the system.

Not surprisingly, almost nine of ten Kansans favored limiting lawyers' contingency fees. Lawyers currently charge one-third to one-half of any award or settlement, plus expenses, as their fee.

Eight of ten Kansans felt that consumers pay higher health care costs because of the effect of large malpractice awards and premiums. This seems to indicate that people know the public pays the bill when premiums and awards skyrocket.

If you have not contacted your Senator and Representative, please don't wait! We need the help of every Kansas physician if we are to have any success this year. We have supplies of the patient mini-brochure available for your use. The mini-brochure is an excellent way to educate your patients about the problem, and at the same time inform them of our reform proposals contained in SB-110. The brochures are available at no cost to KMS members. If you need brochures or additional information, call the KMS office at 1-800-332-0156.

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- Workers Comp Savings
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- 1984 Tax Reforms
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- Cost Containment Checklist Available

Many KMS members have responded to the Professional Liability Assessment by sending in support greater than the $100 requested. We'd like to specially thank and recognize those members who have chosen to make a larger investment in this effort. Since the publication of the January Newsletter, higher levels of support were received from the following physicians:

Gold Club ($1,000 & Over)
John W. Young, M.D.

Bronze Club ($101-499)
Donald D. Goering, M.D.
Banshi P. Kashap, M.D.
David L. Morgan, II, M.D.
Vinod N. Patel, M.D.

Special Thanks to Joan Sehdev, M.D., President of the Shawnee County Medical Society, who is working hard to achieve 100% assessment payment among Topeka physicians!

WORKERS COMPENSATION DIVIDEND PLAN SAVES 21%

Participants in the KMS sponsored workers compensation program saved 21% on their insurance premiums in 1984. This is in addition to the 10% deviation allowed when the policy was initiated. The primary cause of claims over $500 resulted from pushing or pulling on premises and slip, twist or stumble on premises. Please contact the KMS office for enrollment information.

AGING POPULATION

A recently released report from the U.S. Department of Health and Human Services estimates that between 1978 and 2003 the number of persons aged 85 or older will triple to more than 13 million persons. They will place demands on the health care system that will be difficult to meet. A projected 300% increase in health care expenditures is expected between 1981 and 1990.

KMS Legislative Committee endorsed the concept of the legislative proposal calling for the 24-hour licensed practical nursing care in adult care homes if appropriate consideration for those rural areas where cost and availability might require special consideration.

PUBLIC IMAGE

The public image of physicians will be addressed in a major AMA education campaign to increase the nation's awareness that physicians are advocates for their patients. Delegates to the AMA Interim Meeting in Honolulu last December also directed the AMA Board of Trustees to strengthen the AMA efforts to inform the public about changes that are occurring in health care delivery and the impact that these changes will have on quality and access. The AMA action was the result of an effort initiated by the Kansas delegation last year, which picked up support from several other states. Roger D. Warren, M.D., KaMPAC Chairman, was among the leading proponents for the AMA effort.

The next AMA House of Delegates meeting will be on June 16-20, 1985 in Chicago. All members are invited to attend. The deadline for receiving resolutions for consideration by the House will be Friday, March 1, 1985. Resolutions must be sponsored by a member or component society. A resolution introduced by an individual member must have the endorsement of one-third of the membership of the member's component society.

COALITIONS

Physicians and medical societies continue to be the most frequently represented group in health care coalitions after business firms. County medical societies are urged to start coalitions if they are in a geographic area that does not yet have one. By initiating a coalition and being an active participant, organized medicine can help shape programs at the community level that will best serve the health care needs of the patient.

1984 INCOME TAX REFORMS

The IRS issued regulations implementing provisions of the Tax Reform Act of 1984 dealing with the tax treatment of business use of automobiles and certain other property. The rules became effective January 1, 1985.

The rules included stringent new record-keeping provisions that limited the tax-payer's ability to claim credits or deductions unless the business use of the property could be proven by entries in a log book or similar document, with a separate entry for each use.

A public outcry against such detailed record-keeping has resulted in a joint agreement between Congress and the Treasury Department to do away with such strict requirements.

Under terms of the agreement, farmers and business people may claim up to 70% of vehicle use without maintaining detailed records. However, those who wish to claim a deduction for any use in excess of 70% must stil conform to the new reporting requirements.

Responding to popular demand, KMS will sponsor a repeat Tax Reduction Workshop on April 12, 1985, at the Overland Park Marriott Hotel. Watch your mail for details!

SOCIAL SECURITY TAX

Effective January 1, the Taxable wage base for Old Age and Survivors Insurance (Social Security) and Health Insurance for the Aged (Medicare) was increased from $37,800 to $39,000. The tax rate was increased from 6.7% to 7.05% for employers. You are required by law to deduct 7.05% from each employee paycheck until the person's earnings reach $39,600.

PUBLIC "SCHIZO" ABOUT HEALTH COSTS

A special report in New England Journal of Medicine entitled, "Public Attitudes About Health Care Costs: A Lesson in National Schizophrenia" reveals that (1) The public and government officials see rising costs as the primary health-care problem, but give it low priority among national issues; (2) Although concerned about health care costs, most Americans feels that too SMALL a percentage of U.S. Economy is devoted to health care; (3) Although most Americans find fault with current health care delivery, they don't want to change it; (4) Most people support cost containment measures only if their own personal arrangements are left intact; and (5) Practicing physicians tend to influence public opinion more than groups who advocate changes.



The BROADMOOR
COLORADO SPRINGS, COLORADO

The 126th Annual Session of the Kansas Medical Society is fast approaching. It will be held May 1-5, 1985, at the Broadmoor, Colorado Springs, Colorado.

If you have resolutions for consideration by the KMS House of Delegates, please forward them to this office without delay. March 15, 1985 is the deadline for receiving such resolutions.

LAB SERVICES FOR MEDICAID

SRS has been prohibited by the federal government from paying for laboratory services not performed in the physician's office. Henceforth, only those physicians may bill for Medicaid laboratory services who do the lab work in-house.

BC/BS PAYMENT SYSTEMS

According to the latest word from the Blues, non-automated Medicare claims will continue to be reimbursed on a weekly basis until April 1, 1985, when the paperless claims system is scheduled to become operational.

Reimbursement for BC/BS private business (other than Plans 65 and D) will continue to be made on a weekly basis whether such claims are submitted as paper claims, paperless claims, through a terminal, or through a computer.

MEDICINE TODAY

A television news program for physicians and health-care professionals airs each Sunday on the Lifetime Cable Network. Called Medicine Today, the program broadcasts clinical and socioeconomic news drawn from the AMA's extensive news and information gathering resources, including the Journal of the American Medical Association and the AMA's nine medical specialty journals. The program airs several times during each Sunday starting at 9:00 a.m., EST, and is carried on the cable network as well as 13 television stations, including WABC-TV in New York and KABC-TV in Los Angeles.

MEDICARE ASSIGNMENT

Kansas is tied nationally for second place with the District of Columbia for the percentage rate of physicians who signed participating agreements under Medicare (52.9%). Alabama is #1 with 53.9%. The Kansas figure excludes the Kansas City Metropolitan Area which is serviced by the Missouri Medicare intermediaries. The lowest rate (5.6%) is in South Dakota. Kansas' neighbors ranked as follows: Colorado (38%); Nebraska, 22.2%; Missouri, 20.5%; Oklahoma, 12.8%.

NOTE: The above are HCFA figures which are based on the total numbers of physicians licensed in the state. Of those MDs who are actually practicing in Kansas (outside KC area) 67% are Medicare participants.

LITERATURE OF INTEREST

Cost Containment Checklist is a 9-page publication describing many practical ways in which physicians can reduce costs. Free. Available through: Order Dept., AMA, PO Box 10946, Chicago Il 60610.

TABLE II
IMMUNIZATION STATUS (DPT) OF REPORTED PATIENTS

0 DPTs = 5 cases (ages 1, 1, 1.5, 2, 2 mos)
1 DPTs = 7 cases (ages 2, 3, 4, 4, 4, 5, 6 mos)
2 DPTs = 3 cases (ages 17 mos, 3 & 5 yrs)
3 DPTs = 4 cases (ages 15, 16, 18, 18 mos)
4 DPTs = 9 cases (ages 1.5, 2, 2, 2, 2.5, 3, 3, 5, 8 yrs)
5 DPTs = 3 cases (ages 6, 7, 7 yrs)
Unknown = 2 cases (ages 2, 3.5 yrs)

TABLE III
CLINICAL SEVERITY AND IMMUNIZATION STATUS OF PERTUSSIS PATIENTS

	Number of Doses DPT Received					
Severity	*0*	*1*	*2*	*3*	*4*	*5*
Mild	3	2	2	0	2	0
Moderate	1	1	0	4	7	1
Severe	1	4	1	0	0	2
Total	5	7	3	4	9	3

months, 2 months). Two were admitted to the hospital (one had severe wheezing and the other was admitted for sepsis workup). One pneumonia patient (age one month) was successfully treated as an outpatient.

Other Presentations: Other presentations included submandibular node enlargement (2), exudative pharyngitis (2), conjunctivitis (2), lower lid edema (5), and purulent rhinitis (3). Several patients vomited, and one continued to vomit for several weeks. The duration of cough ranged from one week to two months.

Previous DPT Immunization: The DPT status of these patients along with the severity of the disease are tabulated as in *Tables II* and *III*. Severity of the clinical disease was classified arbitrarily as mild (mild to moderate cough), moderate (prolonged and persistent cough), or severe (severe cough, often required hospitalization).

Among five patients who had not received any DPT prior to the attack, three were classified as having mild disease (age less than 1 to 2 months). One had pneumonia with wheezing but was treated successfully as an outpatient. One was admitted and was found to be coinfected with Streptococcus pneumoniae (eye culture) and Streptococcus group D (blood culture).

Four of seven patients who had received one dose of DPT suffered severe cough and wheezing and were all treated as inpatients (age range 2-5 months). A 17-month-old who had received two doses of DPT was admitted because of fever and pneumonia. All four patients who had received three doses of DPT (15-18 months) were classified as having moderate disease (severe cough with or without vomiting) and were treated as outpatients. Seven of nine cases in the four-DPT dose group had moderate cough and three had pneumonia.

The three patients who had received five doses of DPT were quite ill, and two required hospitalization. Muscle pain in calf and thigh regions was quite prominent in these two patients, coughing was continuous and quite severe, and abnormal chest x-ray findings were seen. The average duration from the last (fifth) DPT dosage to the attack was 2.5 years.

Treatment

Twenty-one patients were treated with erythromycin. Amoxicillin was used in eight cases, and four were treated with trimethoprim and sulfamethoxazole. One case was treated with cefaclor. A combination of erythromycin and sulfamethoxazole/trimethoprim was used in one case. Most patients recovered satisfactorily. FA was positive in one case which sulfamethoxazole/trimethoprim had been used for treating chronic ear infection for three weeks prior to the development of the cough.

Complications

The most common complication encountered was otitis media (6 cases).

Laboratory Examinations

No anemia was noted (mean hemoglobin was 12 gram per dl). Mean white blood cell counts were 12,400 per cubic mm with relative lymphocytosis (mean of 53.6%).

Discussion

This report details a relatively large number of whooping cough patients seen by one pediatrician. Many local family physicians observed the same trend during the same period. The state of Oklahoma reported its largest outbreak in history in 1983 (330 cases).[1] Since this report is a retrospective study, the percentage of positive FA tests could not be determined. No attempt was made to culture *B. pertussis* during the reporting period since transport media were not available. Many cases would have been missed by the FA test since the latter is not as sensitive as culture by a newly modified culture media.[2]

Unexpectedly, disease observed in the very young (less than 2 months of age) was much milder than would have been anticipated. Only two cases were admitted for in-hospital treatment (wheezing in one case and to rule out sepsis in the other). Several of these younger infants had a mild course and symptoms subsided rapidly with antibiotic administration.

More severe cases were those who were admitted with severe wheezing and were initially diagnosed as having bronchiolitis. Typically, these infants were around 4-5 months of age. Generally these patients responded well to bronchodilator therapy as previously observed.[3] Many of these cases had persistent coughing and swelling of the lower eyelids leading to the suspicion of whooping cough. These cases could have been misdiagnosed as having viral syndrome if the FA test had not been utilized. All of these patients (who had severe wheezing during the pertussis attack) are currently free of bronchoconstriction. No cases of apnea or seizures were noted in this study.

Patients who had the most severe disease were those who received one dose of DPT and fell into the 2-5 months age group. Generally the disease was mild to moderate in those who had received three or more doses, but the cough persisted up to several weeks.

It is not quite clear why those who had received a complete set of DPT (5 doses) were quite ill (two of three cases were admitted for in-hospital treatment). Perhaps these three patients had failed to develop a good response to the DPT vaccine or might have been concomitantly infected by the prevailing respiratory viruses in the winter season. It should be pointed out that the three patients in this group represent only a minority of children who have previously received a full course of DPT vaccine.

Review of the x-rays revealed two common patterns, *i.e.*: (1) hyperexpansion such as would be expected in those with bronchiolitis; and (2) perihilar infiltration which radiated to involve lower lobes, quite often on the right side.

Factors responsible for this outbreak are largely unknown. One plausible explanation would be a decrease in immunization in the community (as a result of nationwide television coverage of adverse reactions to DPT in 1982). As a result, an increase in susceptible children could lead to an outbreak as has been the experience in England and Wales.[4] However, Joseph G. Hollowell, Jr., M.D., of the Kansas Department of Health and Environment, has advised that the percentage of children in this area who are appropriately immunized appears to be reasonable. It is also possible that an increase in susceptible adults could lead to an increase in a pool of asymptomatic carriers and unusually mild cases which in turn served as reservoirs to infect younger patients. Another factor could have been a decrease in the efficiency of the vaccine or vaccine failure. However, from many studies elsewhere in the past, vaccine efficiency has been calculated to be 60-94 per cent.[5, 6]

Side effects of the vaccine have been a major concern, and have led to a reluctance among parents to have their children immunized. Some of these side effects — such as convulsions, encephalitis, shock-like phenomenon, and persistent crying — are quite serious.[7] A recent study of the serological response after a reduced dose of DPT suggested an adequate response.[8] Therefore, it is possible that the booster dose could be reduced to half-dose to minimize side effects.

A new "component" vaccine has been developed and has been tested widely in Japan.[9] This vaccine was associated with fewer side effects and was very potent in inducing the serological response and protection. Currently, there are no comparable clinical data of this vaccine available from western countries. In the United States, it is still suggested that benefits from the current vaccine (as part of DPT) outweigh its inherent risks.[10] Since it is impractical to eliminate the disease from the community with the use of antibiotics (many infected adolescents and adults are probably diagnosed as having "flu" or are asymptomatic) the target population who will develop severe disease (infants to school age children) should be properly protected by immunization.

Pertussis is still with us and will continue to be our diagnostic, therapeutic, and preventive challenge for many years to come.

References

1. CDC Pertussis Outbreak — Oklahoma. *MMWR* 33:2-10, 1984.
2. Gilligan PH: Laboratory diagnosis of bordetella pertussis infection. *Clin Microbiol Newsletter* 5:115-117, 1983.
3. Pavesio D, Pavone A: Salbutamol and pertussis (letter). *Lancet* 1:150-151, 1977.
4. CDC Pertussis — England and Wales. *MMWR* 31:629-632, 1982.
5. Broome CV *et al.*: Epidemiology of pertussis, Atlanta, 1977. *J Pediatr* 98:362-367, 1981.
6. Broome CV, Fraser DW: CDC Pertussis in the United States 1979: A Look at Vaccine Efficacy. *J Infect Dis* 144:187-190, 1981.
7. Cody CL *et al.*: Nature and rates of adverse reactions

(Continued on page 62)

On the Universality of Medicine

SAMUEL P. ASPER, M.D.,* ***Philadelphia, Pennsylvania***

In honor of Dr. Delp, I would like to discuss the universality of medicine, for our globe is shrinking and Kansas City today is as much a locus of international medicine as is Washington, London, or Moscow.

Understanding Among Physicians

"I never met a man I didn't like," said the famed humorist-philosopher, Will Rogers. Well, I cannot be so generous. I feel unkindly toward the teenager who, in calling a friend at 2 A.M., misdials and rings my telephone. I dislike the policeman whom I discover is tagging my car for overtime parking just as the red flag drops on the meter. I lack understanding of the bank clerk who is grumpy when accepting my deposit on which the bank will earn interest to pay her salary. But I can say truthfully, I believe, that I have never met a physician I didn't like.

It has also been said that there is greater understanding between two physicians of different countries than there is between a physician and a lawyer of the same country. I believe it. In my own travels I have on occasion been with a physician whose native tongue was as unintelligible to me as surely mine was to him, yet after an hour of strained effort at dialogue I felt we understood each other well and had established a friendship. Among physicians worldwide there is indeed a bond of friendship, a common sense of mission in life, a shared empathy for the sick, and a joint curiosity about medical science. This is the universality of medicine.

Progress in Medical Science

The 20th century has seen most remarkable advances in medical science. To name only a few, we have seen small pox eradicated from the face of the earth; communicable diseases of children markedly reduced; tetanus and poliomyelitis well controlled; effective treatment developed for tuberculosis and typhoid fever, and even the apparent cure of certain leukemias in children by means of drug therapy. With such expanded scientific knowledge and such feverish activity in research, it may be that the advances we shall witness in the 15 years remaining in this century will exceed those of the first 85 years.

On the other hand, we have seen little progress in the control of certain parasitic diseases, such as malaria and schistosomiasis. Respiratory infection, especially in children in the less developed countries, remains a most serious disease that results in approximately 2 million deaths worldwide each year in children under 5 years of age. Why is the disease so prevalent? Is it because of poverty, malnutrition, overcrowding, environment, lack of immunity? And what is the etiological agent? Bacteria, viruses, fungi, or a combination of agents? How encouraging it was to learn this week that the MacArthur Foundation will use its resources to study schistosomiasis, the world's most prevalent disease. Moreover, the Board on Science and Technology for International Development of the National Academy of Sciences has initiated studies of respiratory disease in children in five less developed countries.

In the main, developed nations have benefitted to a greater extent than the developing nations from advances in scientific knowledge, mainly because the practical applications of the new knowledge are more readily introduced in the former. Moreover, only a few medical scientists in prosperous nations direct their research to the urgent medical problems of the developing world, such as malaria and schistosomiasis.

Thus, impressive as are the advances of this century, they are nonetheless uneven and erratic: that is, some diseases have been conquered and others not, and peoples of some nations have gained more than those of other nations. Nonetheless, we are the grateful legatees of significant scientific accomplishments and we hope to hasten the day for even more.

Communication Among Scientists

Two points relating to phenomena of this century in large measure account for the outstanding advances in scientific medicine of this century. The first point relates to the ease of modern day scientific communication.

Numerous illustrations could be cited to show that

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Address reprint requests to Dr. Asper, Educational Commission for Foreign Medical Graduates, 3624 Market Street, Philadelphia PA 19104-2685.

the rapidity of medical progress is readily attributable to the ease of communication in the scientific world through publications and through travel. It was, for example, Dr. Perrin H. Long who, after reading in the German literature Dr. Gerhard Dogmagk's work with Prontosil in 1935, developed an interest in the sulfonamide compounds. In 1936 Long and his colleague, Dr. Eleanor Bliss, attended a medical conference in London where the English scientist, Leonard Colebrook, read a paper about his success in treating childbed fever with Prontosil. Long and Bliss brought a small amount of the drug to the United States, and confirmed its efficacy in infected mice. The Dupont Company then produced sulfanilamide, and soon there were several other bacteriostatic sulfonamides available for the treatment of infections.

Penicillin, discovered in Great Britain by Alexander Fleming in 1928, was produced in Erlenmeyer flasks in small amounts by the Australian physician Howard Florey in 1942 and found to be remarkably bacteriocidal in man and animals. Following Florey's visit to the United States in 1943, techniques were developed by the Koppers Company for producing this potent antibiotic in very large amounts from thousands of gallons of mould broth. The availability of penicillin just prior to the invasion of France in WW II prevented the deaths of many allied soldiers from infected wounds. German submarines did not prevent the transference of exciting new knowledge and techniques across the Atlantic.

Discoveries in the developing countries also have led to further advances in medical science in the developed countries. For example, in 1962, Dr. Najib Abu Haydar in Beirut described two patients with prominent eyes both of whom had an unusual kind of thyroid disorder known as Hashimoto's struma. While it was well known that bulging of the eyes occurs in some patients with hyperthyroidism, this condition had not previously been observed in patients with any other kind of thyroid abnormality. Soon after Abu Haydar's report, patients at Johns Hopkins and the Mayo Clinic with the same condition were described. These clinical observations in Lebanon and the United States subsequently led the clinical immunologist Dr. Robert Volpe, in Canada, to discover an immunological basis for this unusual clinical phenomenon in both Hashimoto's struma and hyperthyroidism.

Moreover, technological advances today are readily shared among nations. The CAT scanner, an important new diagnostic tool, was first developed in Great Britain and subsequently adopted with technical improvements in Germany, Japan, and the United States. And it was the experiment of a veterinarian in France who catheterized the heart of a horse that led later to the development of this technique in human beings. The procedure is so commonplace today that no cardiac surgeon is likely to carry out elective open-heart surgery without having first obtained direct information on the anatomy and functioning of the heart through cardiac catheterization. Today's jet travel and instantaneous telecommunication make us neighbors of our foreign medical colleagues.

Longevity of Medical Scientists

The second, equally important explanation for the explosion in scientific knowledge in this century is the longevity of medical scientists, especially those in the developed countries. At the beginning of our A.D. calendar, life expectancy was only 25 years, 200 years ago it was 45, and at the beginning of this century it was still only 47. To be sure, there are examples of brilliant scientists of earlier years who were blessed with long productive lives. In his 72 years Louis Pasteur made many discoveries that clinicians and surgeons, like Lister, quickly applied with great success. Most other scientists, however, were not blessed with long life, their careers terminated just as they attained scientific maturity. Today, with life span of peoples in developed countries in the mid-70s, medical scientists have many more years of productivity.

If medicine bonds physicians worldwide, what are the mechanisms that create and facilitate such unity? Surely they include the phenomena just discussed, ease of scientific communication through publications and personal travel, along with continued productivity of medical scientists during a longer, healthier life span. Equally important, however, the advance itself is stimulating to further research. Scientists of today are excited, not in a disorganized, accelerated Brownian movement, but by focused and intense research.

Organizations in International Medicine

The strongest international organization is the World Health Organization. It receives support from most member nations of the United Nations. In 1977 the 30th World Health Assembly held in Geneva, Switzerland adopted a resolution (WHA 30.43) stating that the main social target of governments and the World Health Organization in the coming decades should be "the attainment by all citizens of the world by the year 2000 of a level of health that will

permit them to lead a socially and economically productive life.'' Yet, while WHO has valuable projects in health, such as the one that led to the extermination of small pox, political intrusion hampers some of its worthwhile projects, and its potential for leadership is not being achieved. WHO does not have an arm that facilitates the building of relationships among physicians worldwide.

The late Henry Van Zile Hyde was an innovator, an entrepreneur in the current vernacular, in international medical education. Much of his work was of great value, but his efforts to create a global society of medical schools met with only partial success. Since his death, the World Federation on Medical Education (WFME), the organization he formed, continues under the leadership of the eminent psychiatrist from Edinburgh, Dr. Henry Walton. In 1988, WFME will bring together representatives of regional associations of medical schools with the aim of setting global standards in medical education. Despite the efforts of its current officers, WFME moves slowly toward the goals of its founder and regrettably is not a strong force in international medicine at present.

There are many international societies in specialty fields, such as surgery, internal medicine, immunology, endocrinology, and cardiology. Most of these meet only every two or three years, and the literature that accompanies announcements of these meetings often suggests that sightseeing, as much as or perhaps more than the exchange of new medical knowledge, is their purpose.

Physicians in International Medicine

Although it is characteristic of physicians to bind themselves into groups, organizations and societies, we are nonetheless individuals, each unique in his or her personality, interests, and talents. We must not attempt to place blame on the international medical groups for any apparent weakness. Rather, each of us in his or her limited way should join hands with individual physicians abroad through travel and correspondence. Even more, as Dr. Ralph Crawshaw has proposed, whenever possible each of us should work abroad in association with other physicians and should have foreign physicians work with us for well-defined periods. It is doubtful we shall meet a physician we do not like.

Let us turn to the migration of physicians, an issue of current national and international concern but certainly not limited to the present. Indeed in biblical days so many physicians in the Middle East migrated to Alexandria that the nations from which they had departed complained about the ''brain drain,'' a term now 2,000 years old.

In the history of the United States, many physicians were among the innumerable immigrants from Ireland and Europe received at Ellis Island. One of these was the father of the eminent financier, Bernard Baruch. Dr. Simon Baruch, a surgeon, became chief of staff of Montefiore Hospital in New York City. The greatest influx of physicians from abroad into the United States has occurred, however, within the last 25 years. Anxious to correct a shortage of physicians that became evident in the immediate post World War II period, the U. S. government instituted an ''open door'' policy for immigrant physicians. This former open door policy, coupled with increased numbers of graduates from U. S. medical schools, appears to have led to an overshoot, for it is predicted that we are entering a phase of physician surplus that by the year 1990 may be worrisome.

At present approximately 22 per cent of licensed physicians in the United States are graduates of medical schools outside of the United States and its possessions. There is no doubt that these graduates of foreign schools, approximately 100,000 strong, are serving in important roles in the United States. They are rapidly becoming integrated into our American system of health care and organized medical societies.

Yet, considering the large number of foreign medical graduates, we have inadequate information about them. We *do* know they maintain ethnic ties in organizations such as the Association of Philippine Physicians Practicing in America and the Spanish-American Medical Society. We *do* know that they make up about 20 per cent of medical school faculties. We *do not* know, however, how many keep abreast of scientific medicine by attending courses like this one. We *do not* know how many are fellows of learned societies, such as the American College of Physicians. These are some questions that ECFMG is currently examining and hopes to answer soon.

Why bring up the subject of foreign medical graduates in the United States? In promoting the universality of medicine, these physicians represent an untapped source. Most of them, unlike most U. S.-born physicians who speak only English, have command of one or two other languages. Most of them are well-informed on the social mores and educational systems of their native countries. Accordingly, those who retain a warmth toward their native lands and a compatibility with their home

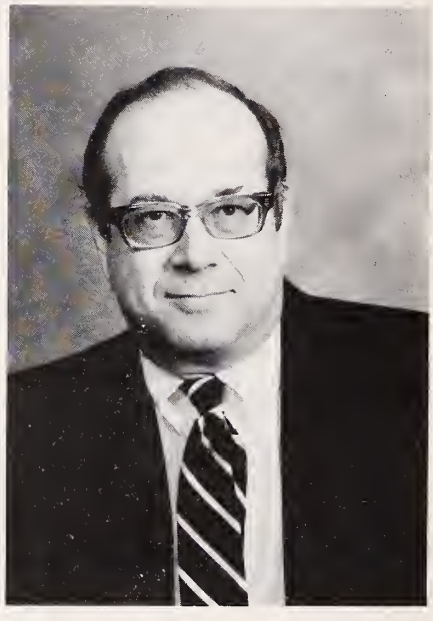
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PRESIDENT'S MESSAGE

In 1980, the Council of the Kansas Medical Society decided to hold the 1985 Annual Meeting at The Broadmoor in Colorado Springs. The 126th Annual Session of the Kansas Medical Society will take place May 1-5 at the Broadmoor. Those of you who have been there know what a fine facility it provides. For those who have never been at the Broadmoor, prepare for a good time.

In addition to the two sessions of the House of Delegates on Friday, May 3, and Sunday, May 5, there are excellent programs. A financial planning seminar is being offered on Wednesday, May 1. The theme for the Meeting is "Ethics in the 80s," and Robert Hudson, M.D., has arranged a program for Thursday, May 2, entitled "The Physician and the Dying Patient." On the morning of Saturday, May 4, the AMA Judicial Council will tackle some of the important ethical questions in the practice of medicine. I have had an opportunity to hear a presentation by the AMA Judicial Council, and these physicians address ethical questions with forthrightness and clarity.

The formal sessions Thursday through Sunday adjourn either at noon or in the early afternoon, so there will be much free time to spend in a lovely place. The Broadmoor is a complete family resort. Several golf courses, tennis courts, swimming pool, shops, a cinema, a variety of restaurants and eating places on the grounds — all these are offered, and more. There are numerous things to do and to see in and around Colorado Springs.



As I look out my window across the cold and snowy scene, I think how different it will be at the Broadmoor in the spring. I hope you are looking forward to being there, too.

Brochures and other information about the Annual Meeting were mailed just a couple of weeks ago. Please plan your schedule and make your reservations soon!

F. Calvin Bayley, M.D.

President

EDITORIAL COMMENT

The Too-common Denominator

The text of the annual Mahlon Delp lecture, given by Samuel P. Asper, President of the National Commission for Foreign Medical Graduates, is presented in this issue of *Kansas Medicine*. Dr. Asper's theme, the universality of medicine, is demonstrated in that peculiar quality of communication that transcends other obstructions to link physicians of different countries. Dr. Asper's remarks are thought-provoking although, to us at least, the thoughts provoked may have veered in directions he may not have intended.

First, our wandering astray was prompted by the thought that while his idea of the universality of medicine seems true and interesting, it raises the question of whether the same sympathetic vibrations do not also exist among the devotees of other disciplines — the law, merchandising, banking, certainly athletes, or any other focus of occupation — which within their confines overlook national prejudices. If so, perhaps the failure to achieve global unity and peace lies in our failure to consolidate these disparate but commonly motivated groups into a cohesive union subordinating the usual international political differences. Dr. Asper points to examples of effective international cooperation in medical efforts, the potential for developing countries to contribute to world medical achievement, the need for this country to share actively in developing that potential, and the possible role of foreign medical graduates in fostering it.

In bringing such efforts into practical effect, however, national interests — that is, politics — have a way of intruding. Efforts of high intention seem to run frequently into obstruction, abuse, or frank rejection. However virtuous the chartered intents, the impotence of the United Nations does not permit one to be particularly sanguine about the prospects of such programs without political blessings. The tragedy of Ethiopia is not solely one of drought — political intrusions have hampered the worldwide response of compassion and generosity and have even been implicated in aggravating the effects of the natural disaster at its origin. Meantime, the powers in many developing countries have demonstrated their willingness to partake of the material benefits offered at the expense of the people.

There have been, of course, relatively small scale accomplishments in taking medical services to deprived areas but these have been largely private, limited, and direct rather than aimed at the development of cadres of native physicians and facilities to bring the quality of medical care of the country up to that of the more affluent nations. The concept of bringing physicians to this country for training with the intent of their returning to offer their services to their countrymen is excellent, but unfortunately has often resulted in benefits to this country rather than the deprived one. This refers not to the "brain drain" (a primarily political effect in itself) where the intent to stay is clear but the instances of those who come for training but succumb to the American siren song. The prospect of returning to relatively deficient facilities, trying to correlate the methods and systems learned here, the loss of intellectual contacts developed here and, above all, the political conditions at home, enhance the determination to continue here unless the dedication is unusually strong. At the same time, the distinction must be made that the "FMG" designation still includes those American citizens who have gone outside the country for their medical educations with no intent but to return here as soon as possible.

The conviction of an actual or impending excess of physicians in this country is growing. Medical schools are reducing admissions and efforts are developing to restrict the influx of foreign nationals. Since stateside schools always will have more applicants than they choose to accept, there will probably continue to be a demand for the extraterritorial schools as the qualified ones improve their products — and the deficient ones succumb.

The universality of medicine will continue despite the interference of international politics. The ways in which medical capabilities can be extended to less privileged areas are still problematic. But perhaps the problem begins closer to home. It is hoped it will at least survive the effects of medical politics. — *D.E.G.*

SPECIAL FEATURE

KAFP Doctor for a Day

"Is there a doctor in the (state) house?"

Yes, and there's been one there nearly every day during Kansas legislative sessions for the past six years. Last month the Doctor for the Day office opened for business for the seventh time.

Located in a miniscule room tucked into a corner adjacent to the Senate gallery, the office is staffed by members of the Kansas Academy of Family Practice. The project was conceived and organized by William R. Lentz, M.D., Topeka; Richard R. Brummett, M.D., Salina, and Donald D. Goering, M.D., Coldwater. It was initiated by the Academy in 1978.

Academy members volunteer to serve one day each in the office. These physicians come from all sections of Kansas, yet seldom has one of them failed to keep his/her commitment without adequate notice to arrange for a substitute — a remarkable accomplishment in view of often fierce and unpredictable winter weather. The legislative session lasts for 90 days, and the overwhelming success of the program is a tribute to the dedication and commitment of the KAFP member physicians.

Volunteers are scheduled by Gene and Sally Wilcox in the executive office of the KAFP — no small feat with a statewide dispersion and daily turnover of personnel.

In 1984, the program was expanded to include staffing during the Silver Haired Legislature in November.

A normal day's caseload is from four to twelve patients. Upper respiratory ailments are most numerous, but treatment has been provided for a variety of afflictions including allergic and diabetic reaction, fractures, lacerations, and sprains. It should be no surprise that there are frequent requests for blood pressure checks!

Office space is donated to the project by the state, and some emergency equipment is supplied by St. Francis Hospital in Topeka. The Kansas Division of Legislative Services pays for basic medications, which are supplied at cost by the Medical Arts Pharmacy. Each physician brings his/her own stethoscope and prescription pad.

The office has a sunny south window that affords a sort of Grandma Moses panorama of the capitol hustle and bustle on the statehouse grounds three stories below. Or time between patients can be spent in the hall visiting with lobbyists or other Senate observers.

The project is an ideal public relations and communications link between physicians — who have a great deal at stake in contemporary legislation — and legislators — who sincerely appreciate the availability of medical services. The KAFP, through its sponsorship of this program, makes a substantial contribution of goodwill, and all Kansas physicians are the beneficiaries.

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Amitriptyline Overdose

(Continued from page 51)

come resulted from these differences in treatment or if our patient survived because of earlier intervention. However, it is hoped that this detailed case history may provide useful information to others who are faced with the same problem.

Reference

1. Silverman R, Fromenbaum N: Cardiovascular complications of a drug overdose. *Case Studies in Cardiac Emergencies* 5(4):July 1984.

Pertussis

(Continued from page 54)

associated with DPT and DT immunizations in infants and children. *Pediatrics* 68:650-660, 1981.

8. Darkin RM *et al.:* DPT reactions and serologic response with a reduced dose schedule. *J Pediatr* 105:189-194, 1984.

9. Sato Y *et al.:* Development of a pertussis component vaccine in Japan. *Lancet* 1:122-126, 1984.

10. Hinman AR, Koplan JP: Pertussis and pertussis vaccine: Reanalysis of benefits, risks and costs. *JAMA* 251:3109-3113, 1984.

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Med-Video Clinic

Med-Video Clinic is a weekly continuing medical education series of one hour clinical programs for physicians on cable television. A broad range of subjects is covered; for example: common skin disorders, pain management, neurological exam, obesity, hypertension, rehabilitation after myocardial infarction . . . and more. Each program presents an in-depth analysis of the physiology, etiology, diagnosis, treatment and prognosis of the topic.

In conjunction with recognized experts in each field, the programs are produced at various leading medical centers. Real-life situations are simulated to augment the interest and direct application of clinical content. Program moderator Johanna Shaw, M.D., introduces the topic, summarizes complex information, and identifies latest state-of-the-art developments.

The AMA's Continuing Medical Education Advisory Committee Evaluates each program for current clinical, scientific, and procedural accuracy and relevance. All programs in the series qualify for CME Category I credit toward the AMA Physician's Recognition Award.

Beginning January 6, 1985, Med-Video Clinic will be aired on Lifetime Cable Network's *Doctors' Sunday*. Each Sunday, Lifetime will devote 24 hours, from 6 a.m. Monday morning, to programming for a physician audience. The regularly scheduled programs will periodically recycle so that physicians can choose the time to watch and can return to a program later if viewing is interrupted. Refer to your local cable/TV guide for specific channel and time.

Study guides (with tests) are available to physicians on request for $5.00 each, which covers the printing, first-class postage and handling costs.

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Universality

(Continued from page 57)

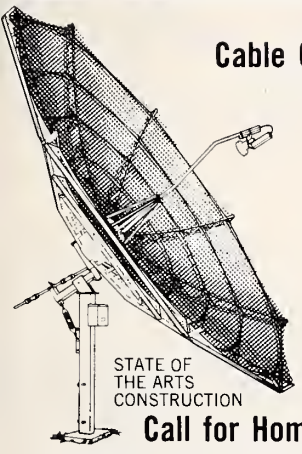
governments should be encouraged to assist directly or indirectly in the education of physicians as well as in providing health care to their peoples.

National and Individual Obligation

In two days, the presidential candidates of our two major parties will debate American foreign policy in this city. I hope they will present their views on international health and medical education, and I pray their views are similar. Sadly, our nation in recent years has decreased its interest and involvement in global medicine. Our superb facilities and faculties for medical care, education, and research are not being used adequately or appropriately for the training of selected foreign physicians who later return to serve their home countries. These are issues for consideration not only by our government, our medical societies and our philanthropic organizations, but also by each one of us.

The French expression "noblesse oblige," translated, means that high rank or birth carries a concomitant obligation for honorable, generous, and responsible behavior. We American physicians, fortunate in having a high quality medical education, have a moral and ethical obligation to participate in the efforts to advance global medicine, health care, and research for the benefit of humankind.

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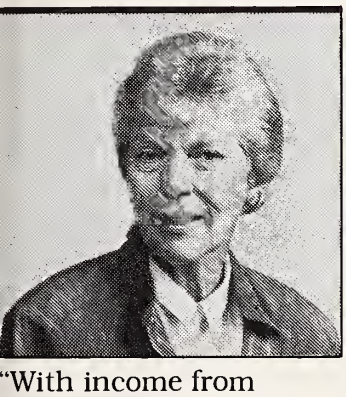
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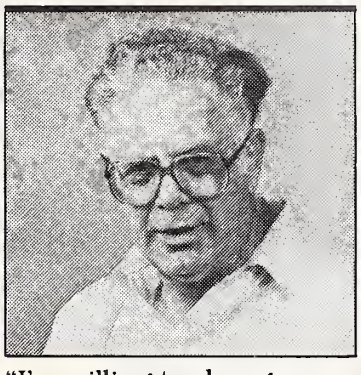
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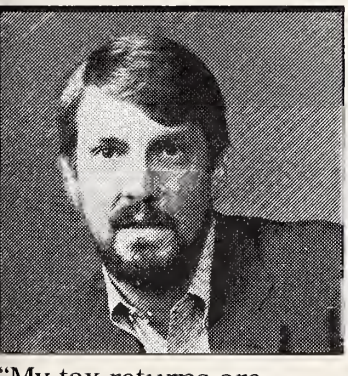
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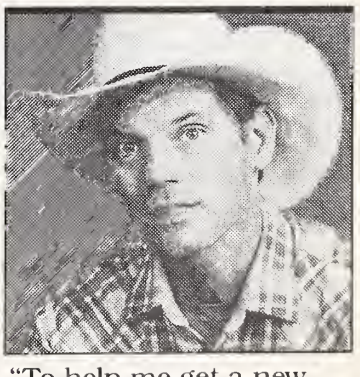
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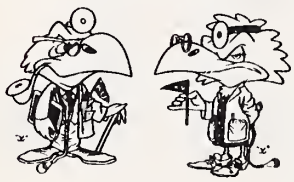
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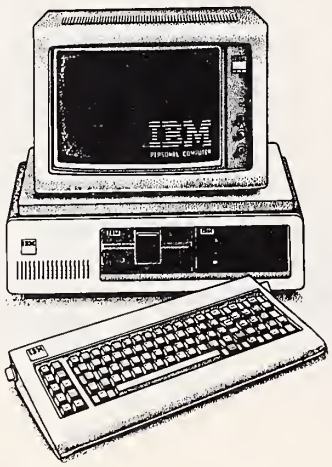
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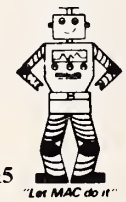
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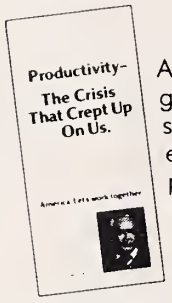
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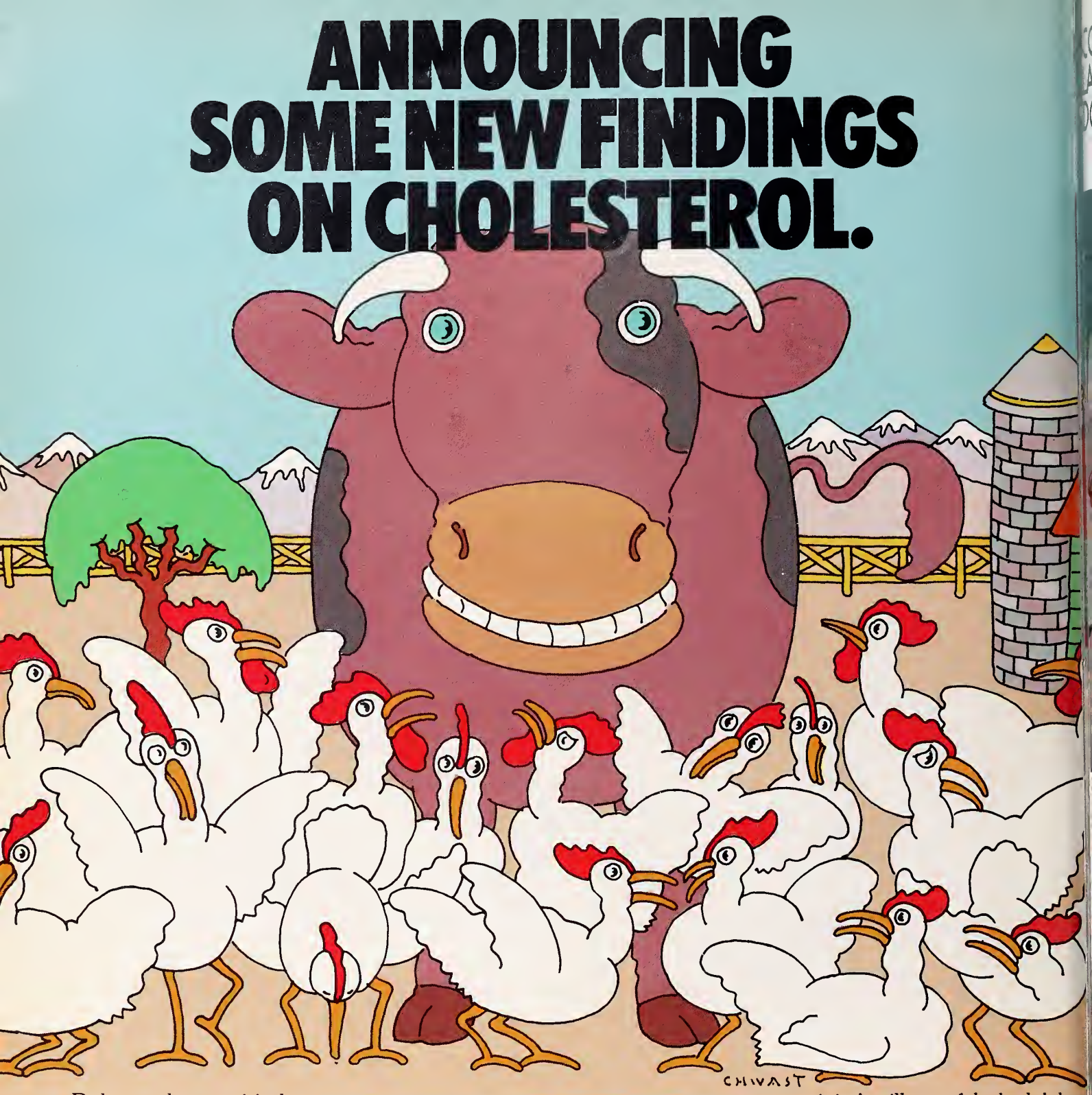
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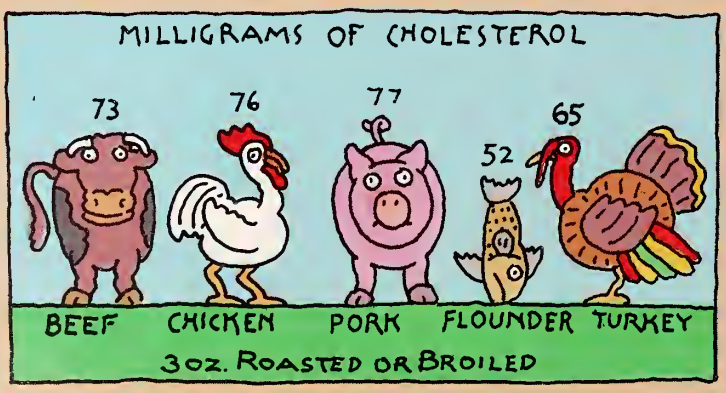
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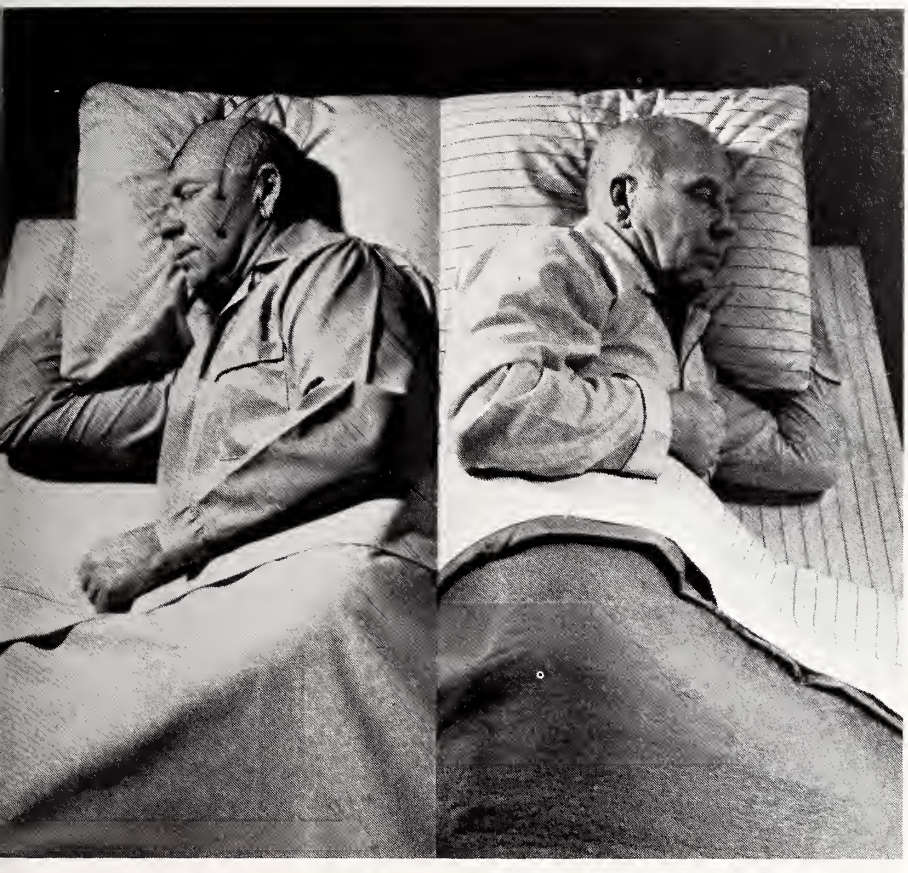
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References: 1. Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al. Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al. Pharmacology 26*:121-137, 1983.

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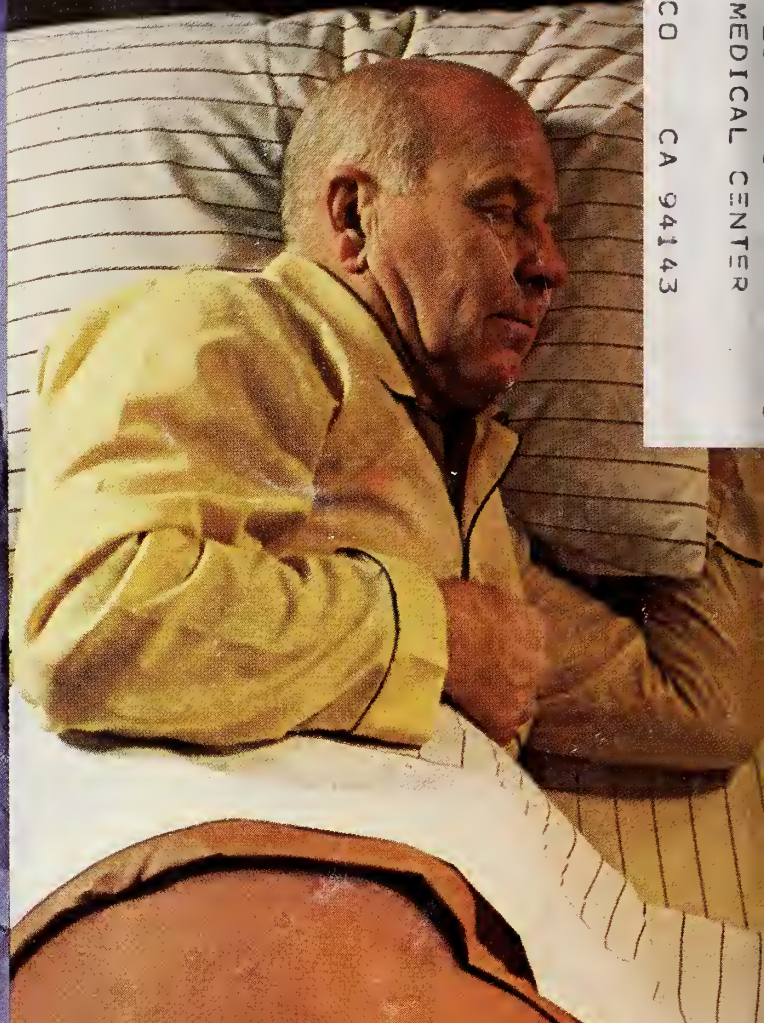
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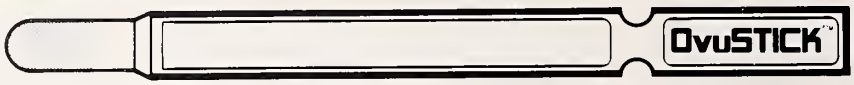
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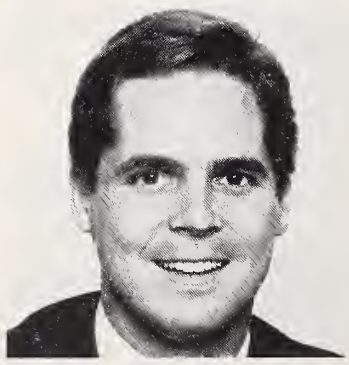
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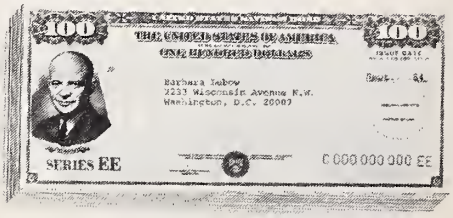


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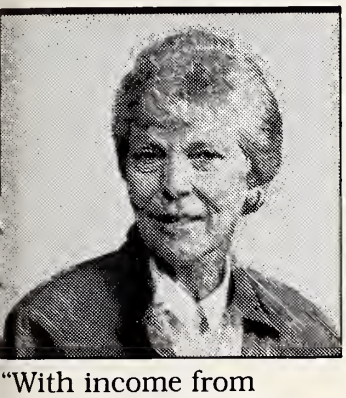
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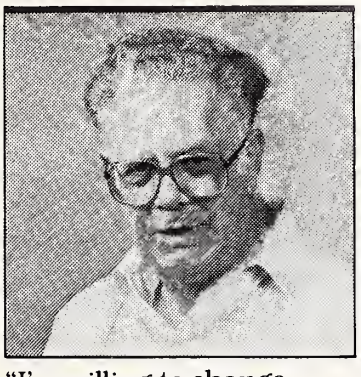
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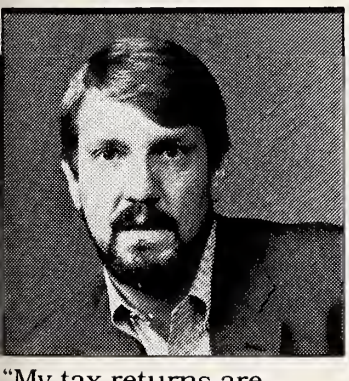
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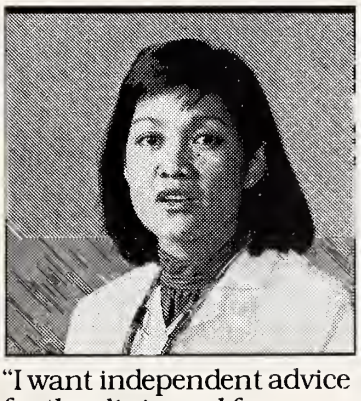
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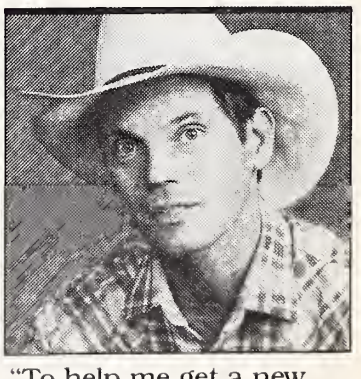
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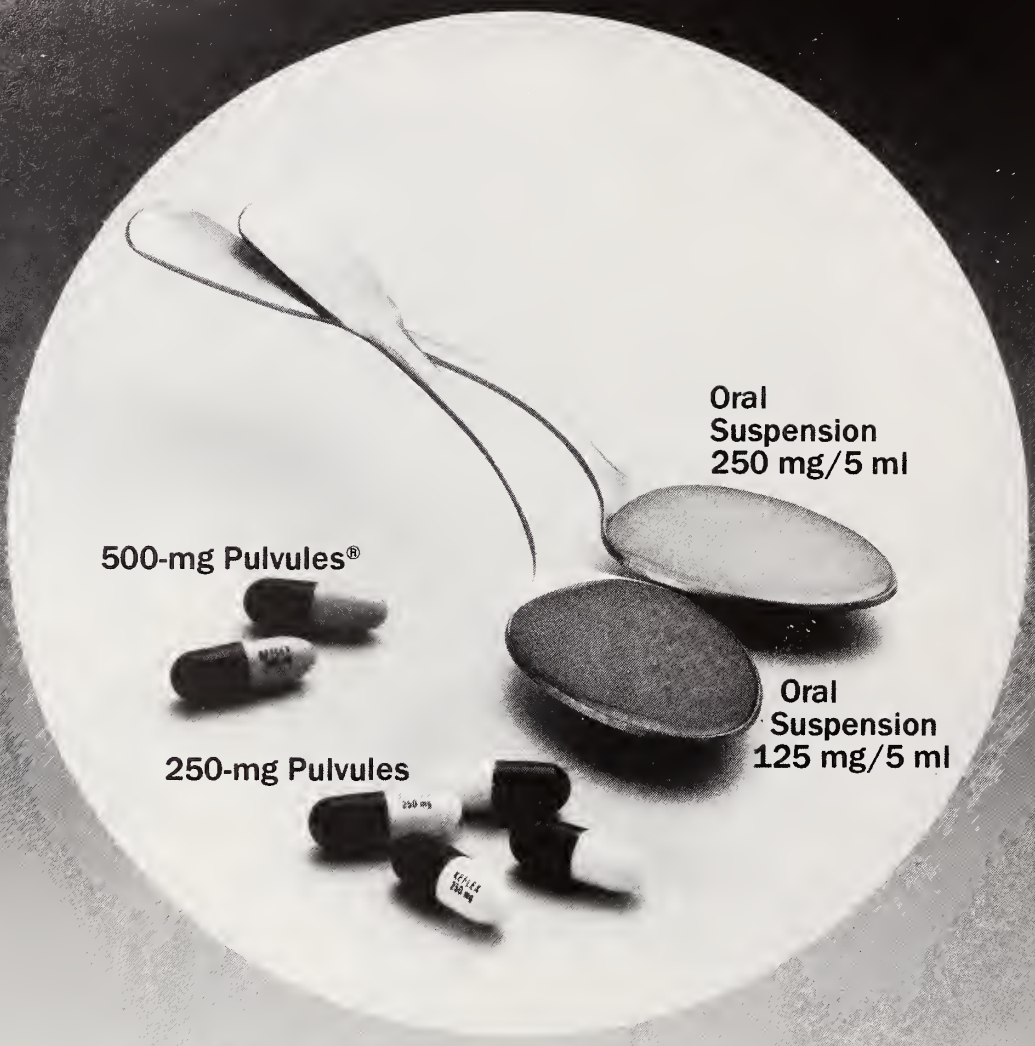
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SCIENTIFIC ARTICLES

Evaluation/Treatment of Acute Knee Injuries

GARY L. HARBIN, M.D., *Salina*

THE POPULARITY of competitive high school, college and casual sports has generated a high incidence of knee injuries. It is likely that the medical practitioner will frequently be required to examine acute knee injuries. A significant number of these injuries will display marked effusion and instability. The proper diagnosis is critical to the future outcome of the knee's function and stability, and its importance cannot be over emphasized. The overlooked medial collateral ligament and associated anterior cruciate tears can lead to permanent instability and loss of the individual's ability to function in a casual or competitive sport. It must be fully understood that injuries not only follow major traumatic events, as occurs in a sporting injury or vehicular accident, but also can occur simply with twisting, acceleration, or deceleration without direct contact.

The care and treatment of the knee injury may be somewhat controversial, but if the exact diagnosis is known, then a proper avenue for treatment can be chosen. It is important to elicit the patient's individual goals, his or her working environment, and preinjury activity level to determine the proper method of treatment. Overall, young athletes should be treated more aggressively following injury to ensure as good a result as possible and to restore these patients, insofar as possible, to their preinjury status.

History

The patient's history is important. The lack of knowledge of a prior major knee injury could lead to a fallacious judgment on the amount of instability present. Immediate swelling would be more likely to occur with a major tear of the anterior cruciate or patellar dislocation. Minimal swelling and a great deal of pain associated with instability may be compatible with a medial or lateral collateral ligament tear due to the fact that the capsule has torn and the blood will extravasate through this tear and therefore not develop into a large effusion. The ability to fully extend the knee just following the injury would indicate the knee is not locked from a displaced meniscus tear. However, if the knee swells post injury this will block full extension making it more difficult to eliminate the possibility of a displaced meniscus from the diagnosis. A patient's report of a tear or pop is inevitably reliable, and some type of ligament tear or patellar dislocation is likely. With major ligament tears and isolated medial collateral ligament tears, the patient will often relate sensations of instability when walking. The location of the pain is important (whether it is patellar, medial, or lateral) in deciding on what structures are injured. If the patient has a knee hemarthrosis there is approximately a 60 per cent chance of an anterior cruciate ligament tear.[5]

The mechanism of the injury is important, and the patient must be asked whether s/he was hit on the outside or the inside of the knee, whether it was a twisting, deceleration injury, or exactly how it occurred. A hit on the outside of the knee requires a look at the medial collateral ligament; a hyperextension of the knee coming down from a rebound while playing basketball would be likely to injure the anterior cruciate. The importance of the patient's history to the evaluation of the injury cannot be over emphasized. *Figure 1* is a form that can be utilized for recording the history and performing the examination of the patient with a knee injury.

Examination

The history will point the practitioner in the direction of the diagnosis but the examination should confirm the diagnosis. Observation of the patient's *gait* will often give an indication as to the severity of the injury. *Range of motion* in degrees of extension and flexion will sometimes be limited by an effusion but also is limited by pain and severity of the injury. The amount of swelling is important, as mentioned previously. A mild or moderate amount of swelling will often indicate a mild anterior cruciate injury, medial collateral, lateral collateral ligament, or possible meniscus tear. A large amount of effusion is

From the Salina Sports Medicine and Orthopedic Clinic, P.A.
Address reprint requests to Dr. Harbin, 523 So. Santa Fe, Salina KS 67401.

KNEE INJURED ____ RIGHT ____ LEFT

HISTORY

NAME _____ AGE ____ SEX ____

NATURE OF INJURY _____

PRIOR INJURY _____ WHEN _____

DID KNEE POP WHEN INJURED? _____

ABLE TO FULLY EXTEND KNEE AFTER INJURY? _____

WHEN WALKING DOES KNEE FEEL STABLE? _____

WHEN DID KNEE SWELL? _____

LOCKING? ____ YES ____ NO GIVING OUT? ____ YES ____ NO

WHERE IS KNEE PAINFUL? _____

OTHER COMMENTS _____

EXAMINATION

LEFT					RIGHT			
EXT _____ FLEX _____				RANGE OF MOTION	EXT _____ FLEX _____			
_____				AREA TENDER	_____			
_____ YES _____ NO				OTHER FINDINGS				
				ABLE TO STRAIGHT LEG RAISE	____ YES ____ NO			
				INSTABILITY TESTS				
1+	2+	3+	4+	EFFUSION	1+	2+	3+	4+
1+	2+	3+	4+	STRAIGHT VALGUS	1+	2+	3+	4+
1+	2+	3+	4+	STRAIGHT VARUS	1+	2+	3+	4+
1+	2+	3+	4+	LACHMAN	1+	2+	3+	4+
1+	2+	3+	4+	INTERNAL ROTATION DRAWER	1+	2+	3+	4+
1+	2+	3+	4+	EXTERNAL ROTATION DRAWER	1+	2+	3+	4+
1+	2+	3+	4+	PIVOT SHIFT TEST	1+	2+	3+	4+
_____ YES _____ NO				ABLE TO STRAIGHT LEG RAISE	_____ YES ____ NO			

OTHER PHYSICAL FINDINGS _____

X-RAY FINDINGS _____

INITIAL DIAGNOSIS _____

PLAN _____

* CIRCLE PROPER SELECTION OR FILL IN BLANK

** 1+ = 0 TO .5 CM., 2+ = .5 TO 1 CM., 3+ = 1 TO 1.5 CM., 4+ = 1.5 CM. OR GREATER

Figure 1. Knee examination form.

often associated with a complete tear of the anterior cruciate ligament, a lesser injury to the medial collateral ligament, or patellar dislocation.

The knee should be examined for areas of underlying *tenderness*. Tenderness at the medial joint line may indicate either a medial collateral ligament injury or meniscus injury. Lateral joint line tenderness would similarly lead to a suspicion for lateral ligament injury or meniscus injury. Tenderness along the medial or lateral border of the patella would indicate the possibility of subluxation dislocation. Tenderness along the medial hamstring or lateral hamstrings often indicates a distal tear to the hamstring. After the knee has been examined and palpated, it should be tested for *stability* and *instability*.

One absolute rule for examination of knee injuries is that both knees should be examined. Examination of the uninjured knee should be carried out first to allow a valid comparison to the injured knee.

The first test should be for straight *varus* and *valgus laxity*, as they are good indicators of disruptions of collateral ligaments. The knee is held in 30 degrees of flexion and is stressed into either varus or valgus *(Figure 2)*. Both knees should be examined and if the injured knee opens more than the normal

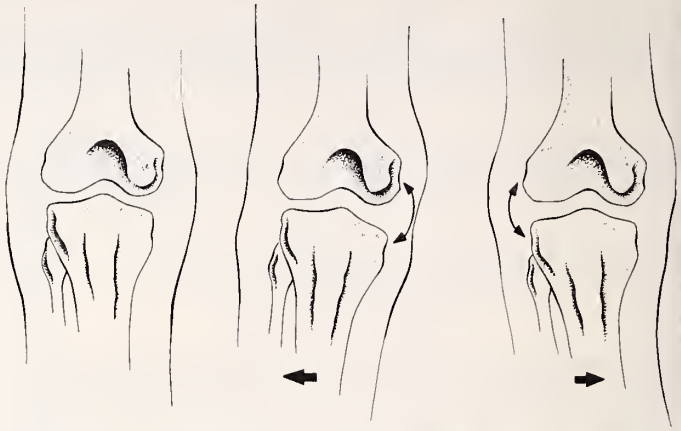


Figure 2. Varus and valgus stressing of the knee is performed at 20 to 30 degrees of flexion. Instability will result in abnormal opening on the side of the torn ligaments, usually a torn collateral ligament.

knee, there is an injury to the collateral ligament. When the knee is unstable to varus or valgus stressing in full extension, injury to the posterior cruciate ligament should be suspected.

The *Lachman* test is a reliable test for the status of the anterior cruciate ligament which is performed with the leg relaxed and is usually not painful[6] *(Figure 3)*. To perform this test, the knee is placed in approximately 20 degrees of flexion with one hand stabilizing the femur and the other hand trying to anteriorly displace or translate the tibia. With the

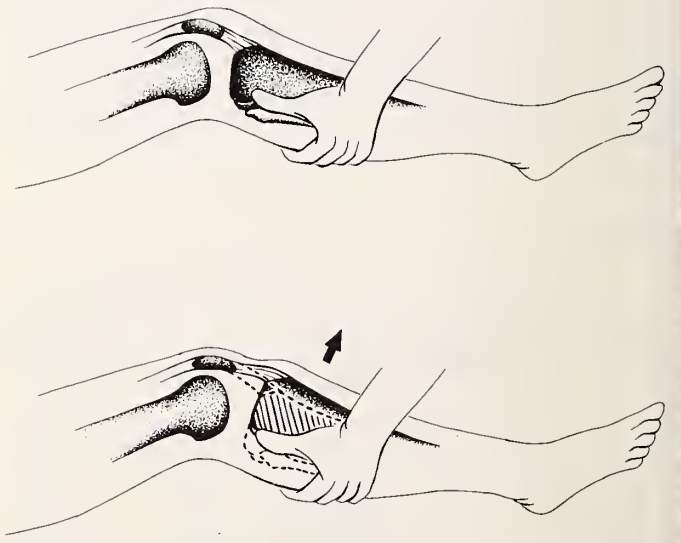


Figure 3. Lachman test. This is an invaluable test for injury to the anterior cruciate ligament. With the knee at 20 degrees of flexion and the hamstrings relaxed, the tibia is pulled anterior. Excess motion is indicative of a tear to the anterior cruciate ligament.

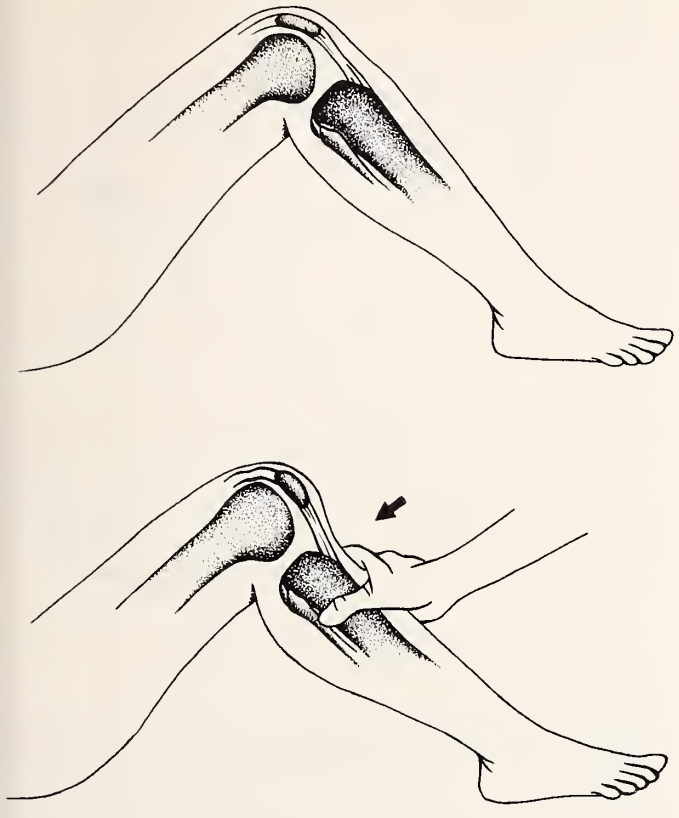


Figure 4. Posterior drawer test. Posteriorly applied pressure on the tibia with the knee at 90 degrees will result in excessive posterior translation of the tibia in face of a torn posterior cruciate ligament.

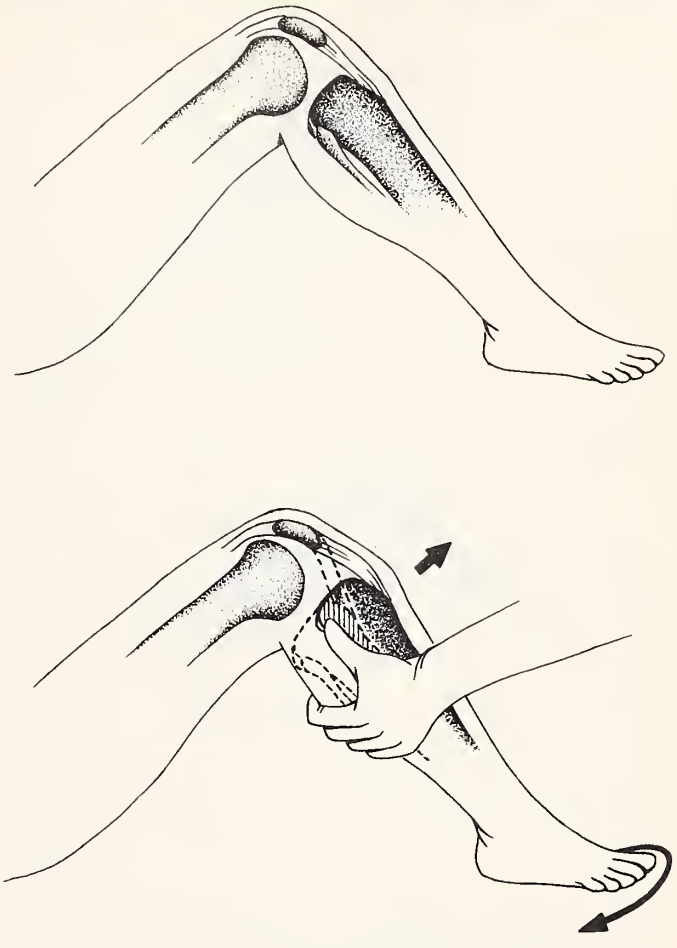


Figure 5. Anteromedial instability test. Externally rotating the tibia with the knee at 90 degrees will tighten the medial structures of the knee. The drawer test then performed will be a test of the anterior cruciate and medial secondary restraining structures.

hand stabilizing the femur the hamstrings must be constantly palpated to make sure they are relaxed while the test is being performed. If there is significant straight anterior translation of the tibia, there is an anterior cruciate ligament tear or insufficiency. It is also important to grade the amount of anterior translation of the tibia noted during the Lachman and other test into grades 1, 2, 3, and 4. (Grade 1 = 0 to 0.5 cm, Grade 2 = 0.5 to 1 cm, Grade 3 = 1 to 1.5 cm, Grade 4 greater than 1.5 cm translation.) Grades 3 and 4, which would be much more severe in anterior translation, may require surgical intervention for reconstruction or repair of the anterior cruciate ligament while grades 1 and 2 may be treated conservatively.

The *posterior drawer* test *(Figure 4)* is performed with the knee in 90 degrees of flexion and the foot in neutral. It is sometimes difficult to discern the difference between the anterior and posterior drawer tests but when the tibia is translated posteriorly to the femur, the area over the tibial tubercle will sag in relationship to the uninjured knee. This indicates a posterior cruciate ligament injury. This injury is uncommon, and is often associated with pain and swelling in the popliteal fossa, and usually requires definite aggressive treatment.

The *anterior drawer test* should be performed for antero-medial instability and for antero-lateral instability. The anterior drawer test with the foot externally rotated is a test for *antero-medial instability (Figure 5).* The knee is placed at 90 degrees of flexion and the foot externally rotated (which tightens the medial capsule); the tibia is then translated anteriorly in relationship to the femur.[4] This indicates injury to the anterior cruciate ligament and posterio-medial capsule of the knee.

The test for *antero-lateral instability* is performed by placing the foot into internal rotation and again trying to anteriorly displace the tibia *(Figure 6.)*[1] There is often more natural antero-medial instability than there is antero-lateral instability. If a significant amount of antero-lateral instability is present, it may

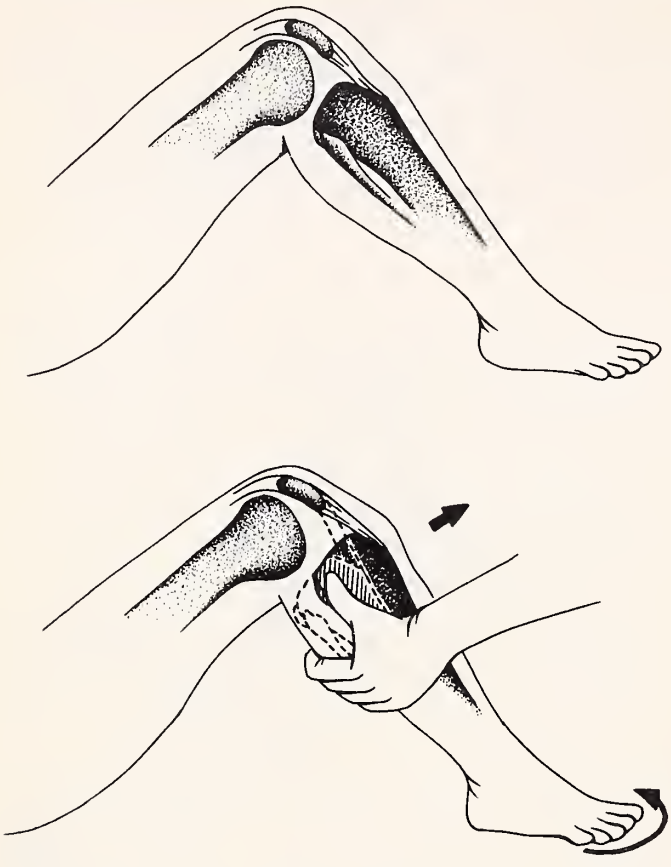


Figure 6. Anterolateral instability test. Internally rotating the tibia with the knee at 90 degrees will tighten the lateral knee supporting structures. The anterior drawer test performed in this position will test the anterior cruciate and lateral ligament sufficiency.

indicate that the patient will have more difficulty participating in sports later unless treatment is aggressive.

The *pivot shift (Figure 7)* is an important test of stability of the lateral tibial plateau in relationship to the femur and is a good indicator in the acute injury as to possible future functional difficulties unless treatment is aggressive.[2] The test is performed by placing the hand approximately over the lateral joint line of the involved knee, placing valgus stress on the knee, and simultaneously internally rotating the tibia. Then by gently flexing and extending the knee from full extension to 40 degrees of flexion the lateral tibial plateau shifts or subluxes in and out. Often when this test is done it will reproduce the patient's symptoms while walking or participating in sports.

If the clinician is not certain of the degree of injury after the initial examination, or if the knee is too painful, an examination under anesthesia is indicated.

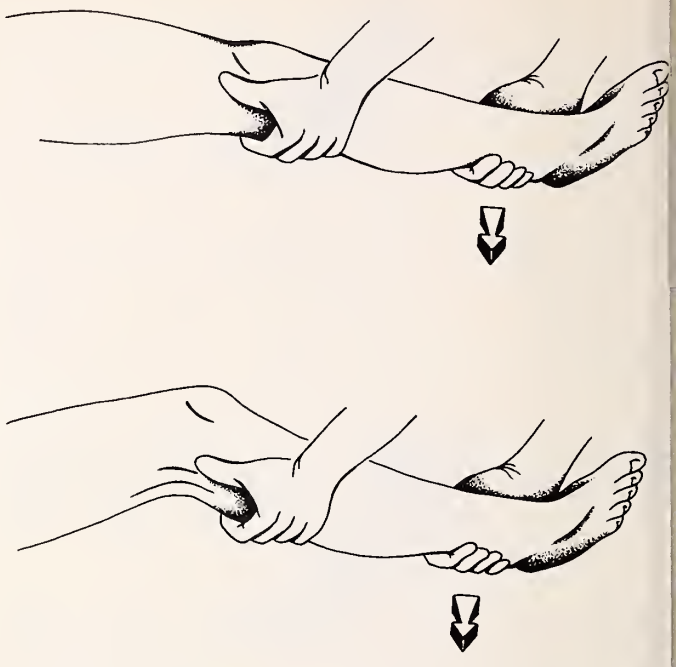


Figure 7. Pivot shift test. This tests for abnormal movement of the tibia in relationship to the femur. As the examiner holds the knee in valgus stress and the tibia internally rotated, the knee is gently flexed and extended. If the pivot test is positive, the abnormal motion is detected at approximately 20 degrees.

X-Ray Evaluation

X-ray findings are important. It is necessary to determine whether the knee has sustained a ligament avulsion injury, an isolated depression tibial plateau fracture, or major joint fracture. If there is considerable effusion present and some difficulty is encountered in examination, the knee can be aspirated and a solution of 10 cc Marcaine and 10 cc Hypaque 50 injected into the knee. This will give an anesthetic effect which will allow a better examination of the knee. An arthrogram can then be obtained along with standard x-rays. If the arthrogram shows the dye leaking from the knee, there has been a major capsular-ligamentous injury. When there is a major capsular injury, procedures such as an arthroscopy are contraindicated. Also, stress x-rays are somewhat easier to obtain after injection of Marcaine and therefore more reliable in determining the amount of the instability.

There are other tests for examination of the knee including the Apley grind test, McMurray test, reverse pivot shift, and jerk test. These tests will not add much pertinent information in making the diagnosis in acute knee injuries.

The history and physical examination of the pa-

tient should give the clinician the ability to properly diagnose the injury in greater than 90 per cent of cases. When treating athletes, the proper diagnosis is very important to avoid any permanent disability and to allow continued participation in high school and college athletics. As noted previously, greater than 60 per cent of traumatic significant knee effusions will be secondary to an anterior cruciate or meniscus tear.[5] There is often a definite need to determine the status of the meniscus. If the meniscus is treated early, it can often be repaired and saved and does not have to be removed. Removal of a torn meniscus in an anterior cruciate deficient knee can actually aggravate the instability. The degree, amount, and location of ligament instability determines the required surgical intervention or nonintervention necessary to obtain a satisfactory functional result. *Figure 8* is a flow sheet of the treatment of acute knee injuries which outlines some possible routes to take in treatment of the knee after the diagnosis has been made from the examination. The first decision-making point follows the stability examination. If uncertainty exists after the initial examination, an examination under anesthesia (EUA) is indicated. If the knee is stable *(flow sheet point a)* — especially if there is a traumatic effusion present — some type of immobilization or functional bracing is necessary for a minimum of three weeks. If only the anterior cruciate ligament is torn *(flow sheet point b),* an EUA and arthroscopy may be carried out. If a meniscus lesion is present, it should be repaired. If a meniscus lesion is not present, the Lachman test is 1+ or 2+ and there is no pivot shift, the patient will do well the majority of the time with a functional bracing system for six to eight weeks. When there is a significant Lachman (3+ or 4+) and/or a pivot shift, a repair or reconstruction of the anterior cruciate ligament may be indicated. If there is definite straight instability *(flow sheet point c)* in the knee, it must be determined whether the ligament needs to be repaired or the individual can be treated conservatively with casting, cast bracing, or other similar methods. If the anterior cruciate ligament is intact and the individual has an isolated medial collateral ligament tear, immobilization or functional bracing followed by rehabilitation may be a method of treatment. If stress x-rays and EUA reveal a torn anterior cruciate ligament and torn collateral ligaments, repair of the appropriate ligaments is indicated. If the patient returns to athletic activities, some form of knee protective bracing may be indicated following any major knee injury.

One common knee injury which may be overlooked is that of patellar dislocations. Often there is a considerable effusion associated with tenderness on the medial side of the patella or femoral condyle. This injury should be kept in mind when evaluating an acute knee injury.

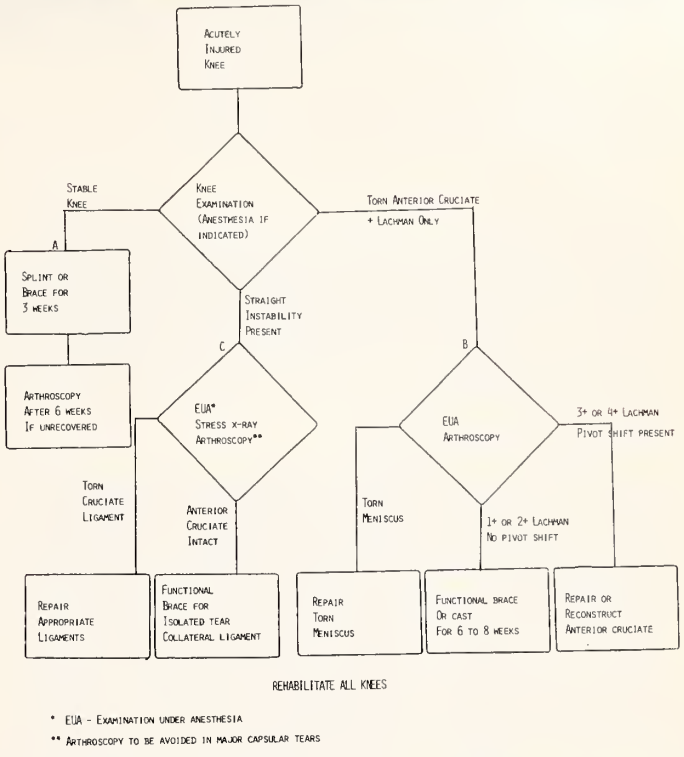


Figure 8. Flow chart for treatment of acute knee injuries.

This flow sheet is meant to serve as a guide to the majority of lesions encountered in acute knee injuries. Often there are gray areas in the evaluation of an injured knee. These gray areas can be eliminated with the utilization of examination under anesthesia, arthroscopy, and arthrography. If the practitioner is able to make the exact diagnosis of ligament instability and injured structures in the knee, appropriate treatment can readily be chosen.

Conclusion

We strongly encourage general practitioners to incorporate a physical examination sheet of the knee, such as shown in *Figure 1,* and a flow sheet in their practice. This will help ensure proper diagnosis and treatment of knee injuries to avoid long term permanent disabilities. The suggested methods of treatments are intended to serve as a guide and are not absolute. The individual practitioner's judgment and the patient's desires and goals are also essential in any decision making. Regardless of treatment

(Continued on page 95)

Management of Carotid Aneurysms

J. E. BOSILJEVAC, M.D., *Emporia*

ANEURYSMS of the carotid artery are unusual. Approximately one of 250 arterial aneurysms occur in this location. The etiology may be atherosclerotic, mycotic, traumatic, postoperative or iatrogenic, and congenital. Two cases and their surgical management are presented.

Patients and Technique

Case One. A 69-year-old white male with a history of hypertension and smoking had a left carotid endarterectomy for hemispheric TIAs, which was complicated by a stroke and residual right hemiparesis. Following intensive physical therapy, he achieved moderate neurologic recovery. Eight months postoperatively he presented with a pulsatile swelling in the left neck. During a six week period, this increased from 3-5 cm in diameter. Angiography demonstrated a false aneurysm arising from the distal common carotid artery and a very tortuous internal carotid artery.

Under general anesthesia, proximal and distal control was obtained over the internal carotid artery and the common carotid artery. The external carotid artery was deep to the aneurysm and could not be controlled initially. Systemic heparinization was performed, and a shunt was inserted distally into the tortuous internal carotid artery. The aneurysm was then opened and the bleeding from the external carotid artery was controlled by means of finger pressure. The aneurysm wall was partially resected and repair was performed using a patch graft of polytetraflouroethylene (Goretex) (*Figure 1*). Before completion of the patch graft, the shunt was removed and reinserted through the proximal internal carotid artery. The internal carotid artery was then closed where the shunt had been removed. The shunt was finally removed before completion of the patch. A small hemovac drain was brought out through a separate stab wound.

Postoperatively, the patient required a nitroglycerin drip to manage severe hypertension. He had been on clonidine preoperatively, and this was felt to be a rebound hypertension. His blood pressure came under control and he was discharged on the seventh postoperative day with no new neurologic deficits. The patient was maintained on aspirin and dipyridamole during the postoperative period.

Case Two. A 69-year-old Mexican-American male had insulin dependent diabetes and a history of heavy smoking. About a month earlier he had been hospitalized for pyelonephritis and E. coli urosepsis secondary to benign prostatic hypertrophy. During this initial admission he developed a septic right achromioclavicular joint which required surgical incision and drainage. He recovered from the sepsis and was discharged but was readmitted with a pulsatile right neck mass. This increased over a period of two weeks to 5 cm in diameter. He was started on intravenous antibiotics but the right neck mass continued to enlarge and to become more tender. There were no neurologic symptoms associated with this mass. Arteriography demonstrated a saccular aneurysm arising at the carotid bifurcation with compression of the distal common carotid artery. He also had occlusion of the left subclavian artery.

He was taken to the operating room and under general anesthesia proximal and distal control was obtained, and the aneurysm was opened. This was a saccular aneurysm involving the distal common carotid artery. The common carotid artery was tran-



Figure 1. Appearance of patch graft closure in *Case One*. The non-resected aneurysm wall can be seen (arrows). CCA — common carotid artery; ICA — internal carotid artery; ECA — external carotid artery.

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KMS

Kansas Medical Society Newsletter

March, 1985

1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

GISLATIVE UPDATE

By the time KMS members receive this Newsletter, the legislature will have reached the halfway point of 1985 Session. Not surprisingly, quite a few issues have yet to be dealt with, and it is expected the last half of the Session will be extremely busy.

As the Newsletter went to press, the Senate was expected to vote on the KMS-sponsored medical malpractice bill, SB-110. After lengthy hearings, the Senate Judiciary Committee made several amendments to the bill and adopted a substitute for SB-110 which includes the following key provisions:

PUNITIVE DAMAGES - In any punitive damage claim against a health care provider, the maximum amount which may be awarded is limited to 25% of annual gross income or $3 million, whichever is less. The intention is, in those few claims which may justify punitive damages, that the health care provider would not be bankrupted by an excessively large award.

PAIN AND SUFFERING AWARDS - The amount of pain and suffering damages which could be awarded in any malpractice claims are limited to $250,000. Studies have shown that juries inflate awards for subjective, pain and suffering damages, and this limitation would help hold down excessively high awards.

COLLATERAL SOURCE RULE - This rule of law presently prevents evidence of medical expenses and other damages compensated from collateral sources from being introduced in a malpractice suit. Under substitute for SB-110, the Collateral Source Rule would be abolished, thus the common practice of "double-dipping" or being compensated twice for the same damages would end.

The Senate Judiciary Committee, in adopting the substitute bill, also indicated that there would be an interim study of the other aspects of the original KMS proposal, including limits on general damages and limits on contingent fees. The passage of the three items listed above is considered to be a substantial victory for the health care industry and a defeat for the trial lawyers group. This is the first time that any limitation on awards, or a comprehensive collateral source rule change, has ever passed the Judiciary Committee (and hopefully the Senate). All three points should have a beneficial effect on the malpractice environment. The collateral

n This Issue...

- Professional Liability Update - SB 110
- PPA Census
- Conflict of Interest
- Your Opinion Solicited
- Reporting of Abuse
- "Kickback" Warning
- Competition
- Book: "Drinking Water"
- Kansas Hospital Regs Changes
- Tax Reduction Workshop April 12, 1985
- Malpractice Workshop March 28, 1985

COMPETITION

Competition is here to stay. This means that physicians must learn to function more efficiently in the marketplace. This issue may constitute the greatest challenge to the standards of professionalism and ethical conduct that has been seen to date. How this problem is handled may well determine how the physicians are perceived by patients and the public.

KANSAS HOSPITAL REGULATIONS

The Kansas Hospital Regulations, which have not been updated since 1974, are undergoing a review and revision. The KMS Committee on Governmental Affairs Subcommittee on Health and Environment, under the Chairmanship of Richard Meidinger, M.D. has collected and forwarded to KDHE a substantial number of appropriate proposals for change. If you are aware of existing hospital regulations which you believe could be improved or should be eliminated, please let KMS know while there is still time for input.

TAX REDUCTION WORKSHOP

The response to our January 18 workshop was so overwhelming that we have scheduled another identical session for April 12, 1985, at Overland Park Marriott. This workshop is presented by the nationally recognized Tax Reduction Institute, one of the largest tax research and education companies in the United States. Come and learn how you can help your accountant make sure you are getting all the tax benefits you deserve. For registration information please contact KMS - 800-332-0156 or (913) 235-2383.

MALPRACTICE '85 ISSUES AND ANSWERS

KMS, Kansas-ACS, Shawnee County Medical Foundation and Stormont-Vail Regional Medical Center have teamed up to present a timely discussion on the subject of malpractice. Scheduled for March 28, 1985, in Topeka, beginning at 10:00 a.m. - 4:30 p.m., the program faculty will include Don Harper Mills, M.D., J.D., University of Southern California School of Medicine, Homer H. Cowan, Vice President, Western Insurance Company, Wayne T. Stratton, J.D., KMS Legal Counsel, M. Martin Halley, M.D., J.D., Topeka and others. The program carries six hours Category I. For registration information please contact Department of Educational Services, Stormont-Vail Regional Medical Center, 1500 SW 10th Street, Topeka 66606 (913) 354-5825.

Mark your calendar . . .

AND COME TO THE BROADMOOR!

KMS 1985 Annual Meeting
May 2-5, 1985

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sected at this point. A shunt was inserted and the distal 2 cm of the common carotid artery was resected. An end-to-end anastomosis was performed over the shunt, removing the shunt prior to completion of the anastomosis. His immediate postoperative course was smooth. About three weeks postoperatively he developed increasing weakness and lethargy, low grade fever, inanition, and severe hyponatremia suggestive of an adrenal insufficiency. No specific diagnosis was made and the patient died quietly about four weeks postoperatively. It is possible he had a brain abscess or an adrenal abscess. There had been no complications from the resection of the aneurysm.

Discussion

Currently, postoperative or traumatic carotid aneurysms are seen more frequently than atherosclerotic aneurysms.[1] A false aneurysm may occur along a disrupted suture line or (in the past) following a direct needle puncture for an arteriogram. Traumatic false aneurysms occur following stab or gunshot wounds, clavicular or first rib fractures, mandibular fractures, and fractures of the transverse process of the atlas. Their natural history is one of progressive enlargement and rupture, and they are associated with a 70 per cent mortality rate within one year.[2, 3]

Mycotic aneurysms are the next most frequent type of carotid aneurysm. They have occurred following a peritonsillar abscess, and may be confused with an abscess. Confusion with an abscess would result in an impressive incision and drainage. More frequently they are seen in drug abusers or with systemic sepsis. Commonly occurring at the bifurcation, they may result from hemorrhage into a plaque with subsequent pressure necrosis of the wall of the vessel. These are also associated with a high mortality rate due to rupture.[2, 3]

Atherosclerotic aneurysms are less common than mycotic or postoperative aneurysms, and 25 per cent are associated with aneurysms elsewhere in the arterial system. Their natural history is unclear, although the danger of rupture is much less than for postoperative aneurysms.[1] Surgery for this type is indicated when patients are symptomatic with hemispheric TIAs from embolization of aneurysm debris.

Carotid aneurysms usually present as asymptomatic pulsatile masses in the neck. If they can be visualized in the pharynx, they surely involve the internal carotid artery. Pressure symptoms include hoarseness (recurrent laryngeal nerve), Horner's syndrome (sympathetic chain), earache (external auditory nerve), or partial paralysis of the tongue (hypoglossal nerve). Rapid growth of a mycotic aneurysm may be confused with an abscess. Embolization with hemispheric TIAs may be seen with any type of carotid aneurysm regardless of the etiology.

Diagnostic tests include sonography and CT scanning. Noninvasive evaluation including OPG or spectrum analysis would demonstrate any flow abnormalities or stenosis associated with the aneurysm. Angiography is still the primary diagnostic procedure prior to any planned surgery.

Mobilization with proximal and distal control is the first step. Resection and end-to-end anastomosis may be possible, or graft replacement or patch graft repair may be used. Many times specific treatment will need to be individualized for each patient.

The decision to use a shunt during surgery should be based on the same criteria as any other carotid operation. If shunts are not used routinely, stump pressures may be helpful in selective shunting. Ligation was the original treatment, but many times resulted in severe neurologic deficits.[1] Stump pressures may also be used in the extreme case requiring ligation.

References

1. Webb, WR *et al.: Aneurysms.* Baltimore, Williams & Wilkins, 1983.
2. Winslow, N: Extracranial aneurysms of the internal carotid artery. *Arch Surg* 13:689, 1926.
3. Busitil, RW *et al.:* Selective management of extracranial carotid arterial aneurysms. *Am J Surg* 140:85, 1980.

Make your reservations NOW for the KMS Annual Meeting, May 1-5 at the Broadmoor

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Malignancy in Immunodeficiencies

KAREN KELLY* *and* NABIH I. ABDOU, M.D., Ph.D.,† *Kansas City, Kansas*

THE FREQUENCY of malignancy in primary immunodeficient patients is approximately 10,000-fold greater than for the general age-matched population.[1] Current evidence shows that not only patients with primary immunodeficiencies are at an increased risk for the development of cancer but also any patients who are immunocompromised due to transplant therapy, patients with cancer treated with chemotherapy, and patients who receive immunosuppressive therapy for nonmalignant disease.[2]

The following is the first reported case of a patient with selective IgA deficiency who subsequently developed acute monomyelocytic leukemia (AMML). Another unique feature of this case is the ability of the patient to tolerate blood transfusions without anaphylactic reactions.

Case Report

The patient was a 56-year-old white male in relatively good health until April 1983 when he contracted "walking pneumonia" which lasted six weeks. Subsequently he developed conjunctivitis, rhinorrhea, and facial edema. By July he was spiking fevers to 39.7C several times daily accompanied by chills, sweats, and a progressive generalized edema. His past medical history is remarkable for selective IgA deficiency, chronic sinusitis, diarrhea, milk allergies, intermittent proteinuria with a normal creatinine clearance, and a 20-pound weight loss during the previous year.

His initial workup in August at another hospital revealed only the IgA deficiency and splenomegaly by CT scan. When transferred to the K.U. Medical Center for further evaluation, he appeared pale, weak, and dyspneic. His temperature was 39.4C, pulse 120, blood pressure was 100/60 with orthostatic changes, and respiratory rate was 18. His conjunctiva were injected and slightly icteric, and periorbital edema was noted. His chest revealed decreased breath sounds with inspiratory wheezes. Cardiac examination revealed a grade II/VI systolic ejection murmur at the left sternal border. The liver was 10 cm to percussion but nonpalpable. A spleen tip was palpable. Extremities showed 2-3+ pitting edema. No lymphadenopathy was noted.

Laboratory results on admission showed a white count of $5.3 \times 10^{-3}/\mu l$ with a slight shift to the left, hemoglobin 9.0 gm/dl, and 120,000 platelets/uL. PT and PTT were 15.1 and 52.7 seconds respectively. Fibrinogen was 44 mg/dl. Abnormal chemistries included a total protein 4.3 gm/dl, albumin 2.1 gm/dl, total bilirubin 2.8 mg/dl with a direct of 2.7 mg/dl, GGTP 485 U/L, LDH 419 U/L, AST 63 U/L, and a uric acid of 10.0 mg/dl. Quantitative immunoglobulins showed an IgG of 1380 mg/dl, IgA of less than 7 mg/dl, and IgM of 303 mg/dl.

A bone marrow aspirate and biopsy revealed acute monomyelocytic leukemia. He was started on Adriamycin, 6-thioguanine, ara-C, vincristine, and Solu-Medrol. Additional supportive treatment included blood component therapy. The blood was given cautiously and no transfusion reactions occurred.

Despite three courses of chemotherapy his condition deteriorated and the patient died.

Discussion

While numerous etiologic factors have been implicated in the development of cancer, the importance of the immune system in oncogenesis is becoming clearer. An increased incidence of malignancy in immunocompromised patients has served to elucidate this association *(Table I)*.[1-7]

The term "immunocompromised" incorporates a wide variety of patients of which primary immunodeficiencies are a small subset. Nonetheless, the observation of malignancy in this group of patients has lead to the establishment of the Immunodeficient Cancer Registrar. As of March 1982, 434 cases have been reported.[8] Of interest is the predominance of lymphoreticular tumors which are otherwise infrequent in the general age-matched population.

Patients with primary immunodeficiencies are a difficult management problem due to their recurrent infections. One should bear in mind that patients

Presented at the annual Kansas regional meeting of the American College of Physicians, March 10, 1984.

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who have persistent signs of fever, fatigue, weight loss, hepatomegaly, and splenomegaly (as our patient did) as well as lymphadenopathy, should be carefully scrutinized for a potential malignancy.

Transplant recipients, because of the intense immunosuppressive therapy they require, comprise the second category of immunocompromised patients. This group has received widespread attention verifying the complication of malignancy as a result of immunosuppressive treatment.[2] Data also show an increased frequency of cancer with time after transplantation which stresses the importance of followup care.[9]

Again, as with primary immunodeficiencies, the incidence of the more common types of neoplasms were not increased. Most often reported were cancers involving the skin and lower lip.[2] These were usually low grade and responded to standard therapeutic regimens without decreasing or terminating immunosuppressive therapy. However, there appears to be a correlation with sun exposure, and patients should be advised and instructed concerning precautionary measures.[10]

Lymphomas represent a disproportionately high number of cases in organ recipients. A unique feature was the frequent involvement of the CNS.[11] Patients with any change in results of neurologic examination should be thoroughly evaluated for the possibility of lymphoma.

Recently, attention has focused upon the occurrence of Kaposi's sarcoma in acquired immunodeficiency syndrome (AIDS) which has also been commonly found in transplant recipients.[10-12] Physicians should have a high degree of suspicion for Kaposi's sarcoma whenever a transplant patient or AIDS patient presents with reddish-blue macules or plaques on the skin or oropharyngeal mucosa, or with a nonhealing granuloma.

Increased frequency of malignancy in the following two groups of patients is just now becoming evident. It has been known that patients with Hodgkin's lymphoma were at an increased risk for the development of leukemia but controversy existed as to whether this was part of the natural history of the disease or due to therapy. Accumulating data on secondary neoplasms in cancer patients treated with chemotherapy and/or radiation suggest the latter to be true.[13] Most chemotherapeutic agents have immunosuppressive side effects, and radiation causes prolonged lymphopenia and decreased lymphocyte reactivity. The role of the agents in the development of oncogenesis remains perplexing because of the numerous variables which must be taken into account. These include the dose, duration, and type of the chemotherapeutic agent, and whether single or multiple chemotherapeutic agents were used. One must also consider the possibility of a direct oncogenic effect of the agents themselves.

TABLE I
INCIDENCE OF MALIGNANCY IN IMMUNOCOMPROMISED PATIENTS

Clinical State	*Frequency of Malignancy Compared to the General Population*
Primary immunodeficiency	× 10,000
Post transplant immunosuppression	× 100
Patients with the following malignancies receiving chemotherapy	
Hodgkin's disease	× 75*
Multiple myeloma	× 100*
Non Hodgkin's lymphoma	× 37*
Ovarian carcinoma	× 21*
Patients receiving immunosuppressive therapy for nonmalignant diseases†	× 1.7‡

* Developing second malignancy.

† Rheumatoid arthritis, ankylosing spondylitis, chronic glomerulonephritis, lupus nephritis, polyarteritis, Crohn's disease, ulcerative colitis, other renal disorders, collagen disorders, and skin diseases.

‡ Majority of patients developed non Hodgkin's lymphoma (× 12) overall incidence 3 per cent.

If chemotherapy results in immunosuppression and subsequent malignancy, can we expect the same phenomena when immunosuppressive agents are used in nonmalignant diseases (*e.g.* autoimmune disorders and chronic inflammatory diseases)? Data supporting this hypothesis have been controversial because it is not known to what extent the underlying disease contributes to the development of the malignancy. However, certain studies support the role of immunosuppressive agents in the induction of malignancy in such patients.[3] The data also suggest a correlation between dose and duration of therapy and the incidence of malignancy. Agents implicated include corticosteroids, azathioprine, cyclophosphamide, methotrexate, chlorambucil, and other cytotoxic drugs.

The mechanisms responsible for the development of neoplasms in immune deficient states are numerous. The leading hypotheses will be briefly explained. A defect in immunoregulation is favored by most investigators.[14, 15] More specifically, tumor antigens cause an increase in T suppressor cells

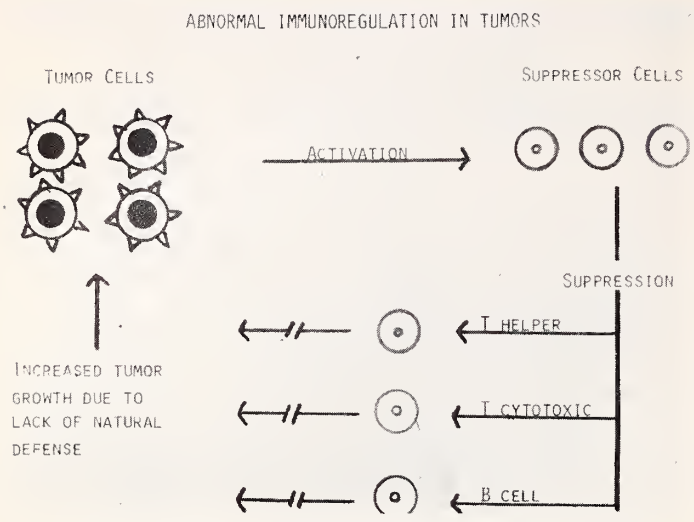


Figure 1. Role of immunoregulation abnormality and suppressor cells in tumor growth.

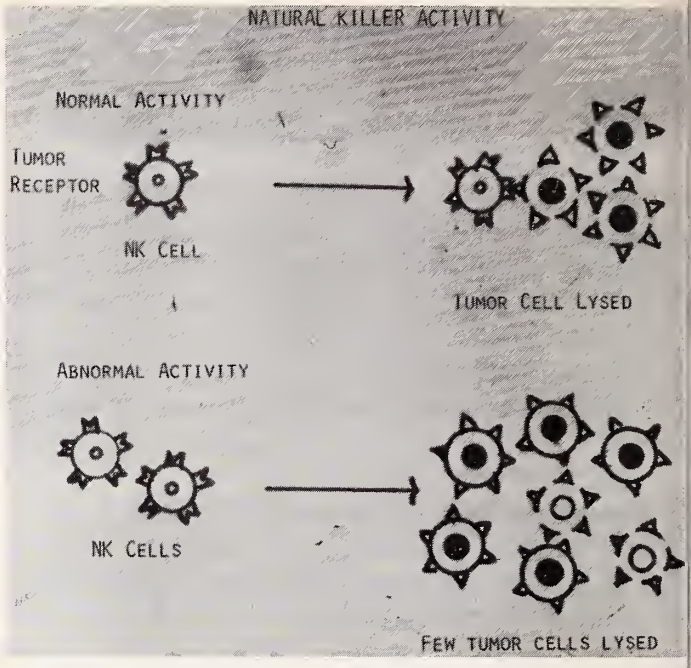


Figure 2. Role of natural killer (NK) cells in enhanced tumor growth.

which inhibit natural defense mechanisms allowing tumor cells to proliferate *(Figure 1)*. Another well accepted hypothesis focuses on natural killer cells (NK cells), capable of an immediate cytotoxic response to tumor cells. Numerous investigations are supportive of NK cells as a primary constituent of immune surveillance.[16] If these cells become defective, tumor growth would be enhanced *(Figure 2)*.

In summary, patients who are immunocompromised for any reason must be carefully followed to detect early signs of cancer. Perhaps, in some cases, early discovery may serve to improve the prognosis and outcome.

References are available on request from Dr. Abdou, Dept. of Medicine, Rm. 4035-B, UKSM-KC, 39th & Rainbow Blvd., Kansas City KS 66103.

CORRECTION

In the January issue of *Kansas Medicine,* the editorial comment, "The Chosen People," attributed an article in *The Pharos* concerning the function of the two sides of the brain to Dr. Steven Mellinek. The correct name of the gentleman is Sherman M. Mellinkoff. With this correction, we tender our sincere apologies and a sigh of relief that we apparently caught the error before someone else did. — *D.E.G.*

PRESIDENT'S MESSAGE

A Letter to My Son

Dear Mark,

You asked me for advice before you enter medical school this summer.

First of all, congratulations! I am proud of you.

Second, as the late President Lyndon Johnson was wont to say, "Ya gotta dance with the gal that brung ya!" If you continue to work as hard as you've done so far, you'll do O.K. in medical school.

Third, I am complimented that you asked me for advice as you start your medical studies. The rest of the letter I've written, rewritten, and discarded many times. I'm sending you some of the rejected material so that you may share my thoughts.

Medical schools have changed since I started studying medicine in 1952. Do you realize that was about the time the first heart-lung machine (cardiopulmonary bypass) was used for open heart surgery in a human? And 1952 was five years before the first regularly scheduled transcontinental jet airline service. There were only a few antibiotics then. Almost all of the drugs for cardiac arrhythmias have been developed since then — many in the past three to five years. Organ transplantation, chronic renal dialysis, modern ventilatory support, the rational treatment of multiple systems failure, hyperalimentation, the eradication of smallpox and poliomyelitis — these and many other advances have been created since I started medical school. The total mass of medical knowledge has burgeoned to staggering proportions. You have a lot more to learn than I did.

There is another major change in medicine in the past 33 years. Medicine is under merciless public attack. When I was in medical school, medicine and physicians were held in universal high esteem — perhaps unrealistically. The malpractice crisis, coercive governmental regulations, high overhead costs, frozen fees, exaggerations and misrepresentations in media reporting — all these and more are pressures on the medical profession, pressures that either did not exist or were of little magnitude when I was in medical school. Maintaining high standards of ethical behavior is very important to the medical profession. We have had a code of ethics since long before Hippocrates. You will be able to sit in on a program presented by the AMA Judicial Council on May 4 at the KMS Annual Meeting to be held at the Broadmoor. The discussion by the Judicial Council of some of the important ethical questions of the day should prove interesting to you. What a paradox that many physicians come under increasingly vitriolic attacks by members of the American Bar Association for alleged unethical conduct when the ABA has never yet adopted an ethical code!

My advice is twofold: First, shut out the controversy and the crowd noise while you do your own thing — much as you did so well in the sport of wrestling. Maintain a high level of concentration as you methodically learn to beat disease, make sick people well, and promote health and happiness. What is the single most important virtue as you grapple with the task of studying humans, their injuries and diseases, and how to bring them back to health? In my opinion it is honesty. Be honest. Be impeccably honest with yourself. With others, temper absolute honesty only with politeness and empathy.

Second, look to your mentors for teaching you in a dimension other than just academic. The physicians on your medical faculty and in your medical school administration know a great deal more than just medicine. Learn also from them about coping with and conquering the sociopolitico-economic threats to the medical profession today and in the future. Look to the KMS and the AMA. Become active in the Student Section of the AMA. Read widely, keep up with current events, be active in your community — even as a medical student.

Have I made the study of medicine sound complex and difficult? Yes, for it is more so than when I was in medical school. Is it worth the effort? As I have told you many times before, I cannot watch any of the medical shows on television because at least two or three times every month (and occasionally several times a day), I personally take part in a real life drama that is more exciting, fascinating, and gratifying than anything you can watch on TV. The chance to genuinely help someone in dire need is worth every bit of time, effort, pain, sacrifice — even the occasional abuse — that the physician takes. I have known heart-rending and gut-wrenching disappointments on the battleline against disease that are unfathomable by anyone who has not struggled through similar experiences. But I have also been a

(Continued on page 95)

EDITORIAL COMMENT

Balancing Act

At this writing, the communication folks are somewhat discomfited because of the conviction of some citizens that they have been badly used. In the case of the print medium, that bastion of journalistic purity that has assured us, *Time* and again, of its infallibility, has come out with a diluted victory: wrong in some of their facts but not libelous which that periodical views as saving face even if there is some egg on it.

Meantime, their electronic cousins are still contending with the General and, in the traditional manner of the media, have wrapped themselves in the toga of the First Amendment (which is getting a little out of shape these days). We hazard a prediction of the outcome: the verdict will probably find that the plaintiff was right enough (with qualifications) and grant the defendant only token remuneration — and both sides will claim victory.

The increased frequency of liability actions in recent years has been addressed *ad nauseum* (Latin phrase suitable to both medical and legal cultures), but we note certain common denominators in the two cases. Both defendants are large corporations with high public visibility. It is easy for the detached individual to feel a certain acceptance, even Quixotish justification, in taking on the soulless monsters. We feel uneasy at their power even as they provide services we need, enjoy, and foster. Their investigative representatives delight in exposing miscreants before vast audiences even as they defend their tactics as required by the significance of the disclosures.

Moreover, no small impetus to the litiginous trend has been produced by the idea that big business could well afford to share the wealth with such individuals or even groups in class action suits. Some financial gain accrued even from lesser awards to avoid the nuisance of longer actions although the circumstances might be questionable.

Although there are many obvious differences between the problems confronting the medical profession and those of other disciplines, there has been more than a little suggestion that the profession, in the public mind, fits that same pattern of power, control over lives and money, and self-interest represented by the more cohesive corporations. The medical defendant is not viewed as another private person but as a representative of a large, closed, profit-motivated, even arrogant corporation peopled by individuals of high income and ample insurance reserves. Coupled with numerous other factors (and not to overlook instances of true malpractice), this attitude, the availability of sufficient lawyers to assist, the well-publicized anecdotal charges of medical malfeasance, and news accounts of large awards (giving the cases unassailable veracity) help neutralize individual reluctance and mobilize the efforts, whatever the justice of the cause.

There may be a changing mood, however. It may be coming through that this whole realm of action has a public cost — medical care, the price of cars, the upkeep of governmental agencies or what have you — not generally appreciated. Although actions are not decreasing, there is some suggestion that those deciding the outcomes and those determining the remuneration are taking notice, and a change in climate may be developing. The phenomenon has become so pervasive that defendants are outnumbering plaintiffs in one context or another. Of more than passing interest in this regard was the public reaction to the descent of American lawyers on Bhopal during its tragedy.

Here at home — and again as of this writing — the Kansas Medical Society has mounted a determined effort to bring a justifiable and responsible balance to the problem of professional liability. As expected, the effort has met with equally determined resistance from the trial lawyers. It seems doubtful that the KMS will meet with unqualified success — such is not the way of these efforts. But one gets the sense that there is increasing national recognition of the need for such a balance. If the effort fails of total accomplishment this time, there will still be reason to feel the tide is turning. That tide turns slowly but that is the way — slow, frustrating, expensive — of checks and balances of the democratic process. — *D.E.G.*

MALPRACTICE '85: ISSUES AND ANSWERS

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PROGRAM

10:00-10:20	Through the Chaff to the Real Issues M. Martin Halley, M.D., J.D.
10:20-10:40	Shawnee County Survey: The "Bad Apple" Revisited Joan Sehdev, M.D.
10:40-11:15	Insurance: Profit or Loss? Homer Cowan, Western Insurance Co., Fort Scott
11:15-11:55	Million Dollar Kansas Cases: Inappropriate Results? Wayne T. Stratton, J.D.
11:55-12:30	Panel Discussion — The Real Issues in Clear Focus
12:30- 1:30	The National Issues Don Harper Mills, M.D., J.D., Los Angeles, California
1:30- 2:30	Risk Management — My Best Advice John Stubbs
2:15- 2:30	The Kansas Medical Society Program — '85 and Beyond Jimmie Gleason, M.D.
2:30- 2:45	The Legislative Environment Jerry Slaughter
3:00- 3:45	Malpractice 1990: Prospects and Directions for Reform Don Harper Mills, M.D., J.D.
3:45- 4:30	Panel Discussion — The Answers

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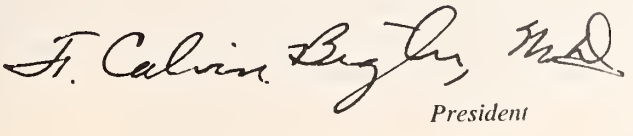
President's Message

(*Continued from page 93*)

participant in many triumphs, and I have even seen a few miracles. This bond between the physician and the patient — call it the physician-patient relationship, or call it whatever you will — this is unique to medicine. A human responds to another human being in need, helping the needy one back to health. Yes, I think you will find that medicine is worth the effort.

I envy you, son. You are embarking on a journey through four years of study. Those years were among the happiest and most memorable in my life. Good luck, and have fun. Four short years from now, when you have completed medical school, I will welcome you as a fellow member of a profession that should hold all the challenges, all the opportunity for service, and all the happiness you could ever want.

Love,
Dad



President

Knee Injuries

(*Continued from page 87*)

preferences, anatomical diagnosis corresponding to the injury is mandatory in the choice of proper treatment.

This information is meant to serve the general practitioner as a guide to the evaluation and treatment of acute knee injuries and not absolute definitive treatment methods.

References

1. Collins HR: *Anterior Lateral Instabilities of the Knee. Symposium on the Athlete's Knee*. St. Louis, C. V. Mosby, pp 184-194, 1980.

2. Galway HR, MacIntosh DL: The lateral pivot shift: A symptom and sign of anterior cruciate ligament insufficiency. *Clin Orthop* 147:45, 1980.

3. Grood E *et al:* Ligamentous and capsular restraints preventing straight medial and lateral laxity in intact human cadaver knees. *J Bone Joint Surg* 63-A:1257, 1981.

4. Larson R: Combined instabilities of the knee. *Clin Orthop* 147:68, 1980.

5. Noyes F *et al:* Arthroscopy in acute traumatic hemarthrosis of the knee. *J Bone Joint Surg* 62-A:687, 1980.

6. Noyes F *et al: Clinical Biomechanics of the Knee-Ligament Restraints and Functional Stability, Symposium on the Athlete's Knee*. St. Louis, C.V. Mosby, pp 1-36, 1980.

SPECIAL FEATURE

Katherine Pennington, M.D., President, MSSC

ELEANOR BELL*

Patients . . . patience. In the pediatrics business, it takes a great deal of the latter to administer health care to the former. And Katherine Pennington, M.D., is now caring for the grandchildren of those who brought their children to her when she first entered medical practice.

Perhaps a youthful patient population keeps the pediatrician young; more likely it's the eternally young who choose to practice pediatrics. But whatever the etiology, Dr. Pennington has effectively combined the spirit of youth with the judgment of maturity during 40 years of pediatric practice and community service. She currently is President of the Medical Society of Sedgwick County, the largest component society in Kansas.

Her patients and their families are important to Dr. Pennington. "One of the best things (about the practice of medicine) is the chance to meet so many fine families. The practice of medicine gives an opportunity to help other people in a very unique way."

A Wichita native who excelled at all educational levels, Dr. Pennington was graduated from the University of Kansas School of Medicine in 1943, one of only eight women in a class of 92 students. She returned to Wichita to practice in 1945 following out-of-state internship and residency programs. During the ensuing years, she has delivered TLHC (tender loving health care) to a large segment of Wichita's pediatric population and, in addition, has served numerous professional, educational, and civic organizations. She has been an active member of a number of KMS committees.

Her special awards include the Distinguished Alumni Award of Friends University (1965); the Meritorious Service Award of the Kansas Heart Association (1964); the Senior Award of the American Association of University Women (1937); and the Wichita Women of Achievement Matrix Award (1979).

* Editorial staff writer.



As she assumes the leadership of the Sedgwick County Society, Dr. Pennington reflects on the concerns shared by all Kansas physicians — erosion of physician-patient relationships by third party intrusion, limitation of individual practice patterns by outside regulatory agencies, and threats posed by litigation "adding a significant cost to medical care and limiting the availability of some procedures."

Of special concern is the "marked increase in the cost of immunizations, and the threatened shortage of vaccines because of product litigations."

"Of all the advances in medicine during my career, I am most grateful for development of an effective polio vaccine. It must be impossible for physicians just starting in practice to comprehend the tragedy of polio epidemics with their devastating crippling effects on robust children."

(Continued on page 98)

Kansas Women in Medicine

There are currently 367 women physicians who are members of KMS. Like their male counterparts, they have varying levels of skills and interests in leadership roles. The physicians profiled here are active in their county medical societies.



Barbara P. Lukert, M.D., Kansas City, a Kansas native, was graduated from the University of Kansas School of Medicine. Following seven years in private practice and Fellowship study in England, she joined the UKSM faculty in 1971 where she is now Associate Professor of Medicine. She has been active in the state and local medical community, and served as president of the Wyandotte County Medical Society in 1978.



Carol A. Moddrell, M.D., Lawrence, came across the border from Kansas City, Missouri to earn her medical degree from the University of Kansas School of Medicine. Since completion of her internship and residency in pathology in 1976, she has been in practice in Lawrence, where she is on the staff of Lawrence Memorial Hospital, and is also deputy county coroner. She has been active in organized medicine at both the local and state levels, and is currently serving as president of the Douglas County Medical Society.



Lunetta M. Pearce, M.D., Shawnee Mission, is a graduate of the University of Nebraska School of Medicine and practiced in Nebraska for two years prior to moving to Kansas. She has been in private family practice since 1961. Her husband, Eugene W. J. Pearce, an obstetrician/gynecologist, joined the practice in 1980, and they are now incorporated as the Pearce Professional Group. Long active in medical society committee work, Dr. Pearce is now president-elect of the Johnson County Medical Society.



Joan Sehdev, M.D., Topeka, completed her medical education in Vancouver, B.C. She practiced in Canada and Africa prior to locating in Topeka in 1967, where she is now in private practice as a family physician. A staunch supporter of organized medicine, she has served the state and local societies in a number of positions. She is currently president of the Shawnee County Medical Society.

Katherine Pennington, M.D.

(Continued from page 96)

Despite the difficulties faced by today's medical community, Dr. Pennington maintains her conviction that physicians "will continue to regard good patient care as our primary goal." She sees organized medicine as the best mechanism for "continuing the opportunity to provide quality, compassionate care to each individual patient. I hope even more physicians will become actively involved in medical societies."

Whether you spell it "patients" or "patience," it's all a part of Dr. Pennington's continuing service to the human community.

CORRECTION

In the feature article, "KAFP Doctor for a Day," published in the February issue of KANSAS MEDICINE (page 60), the sponsor of the program was incorrectly identified. The organization's correct name is the Kansas Academy of Family Physicians. KANSAS MEDICINE regrets this error.

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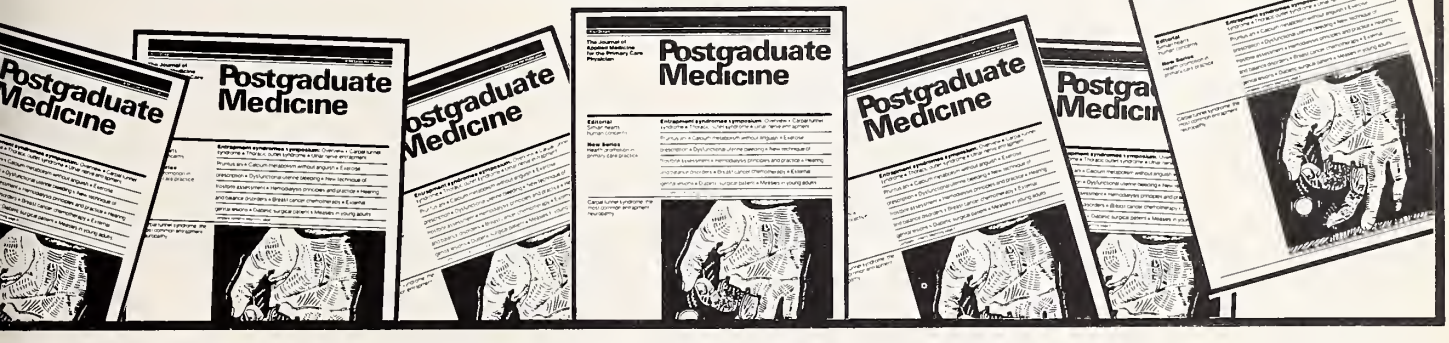
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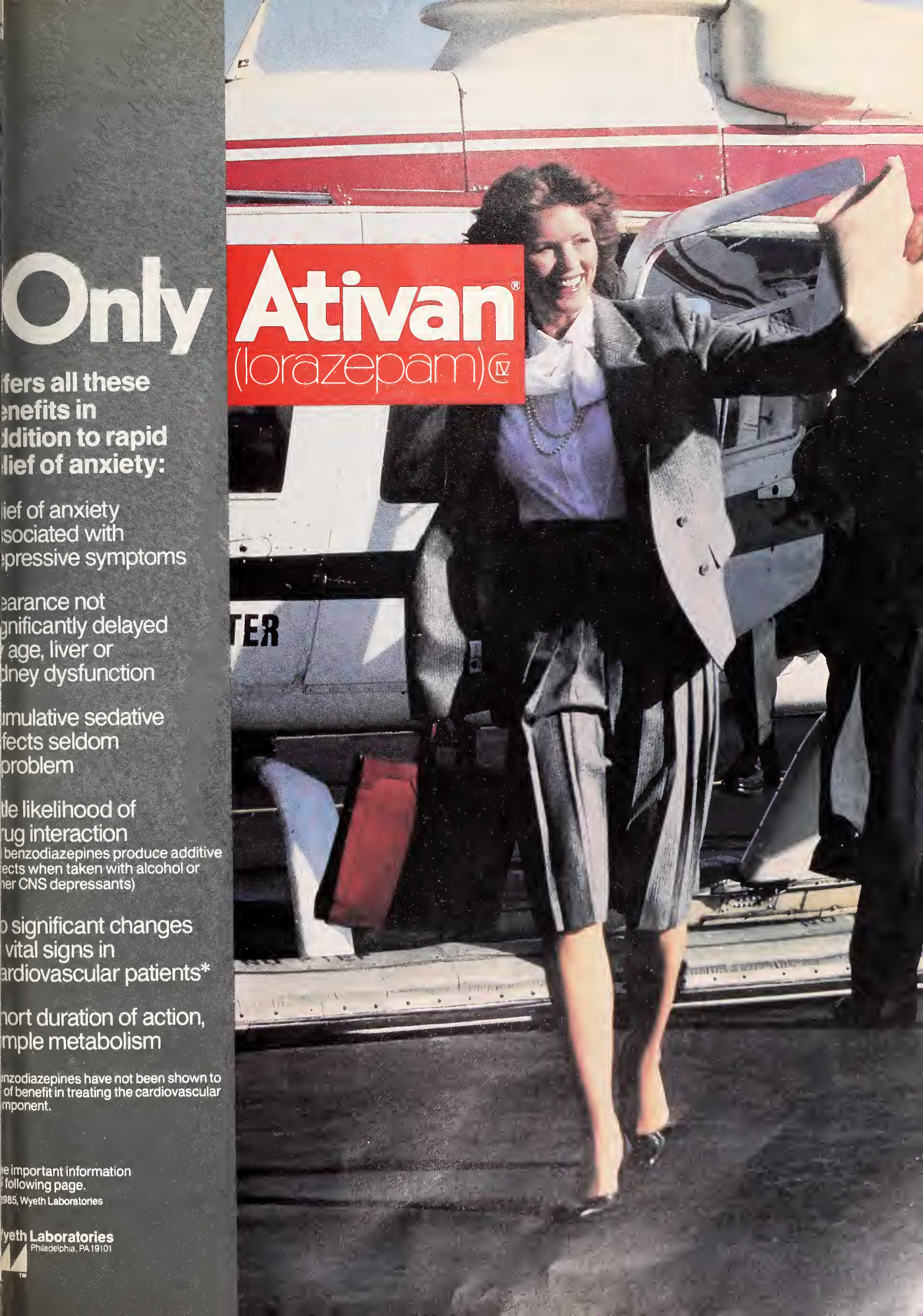
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Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

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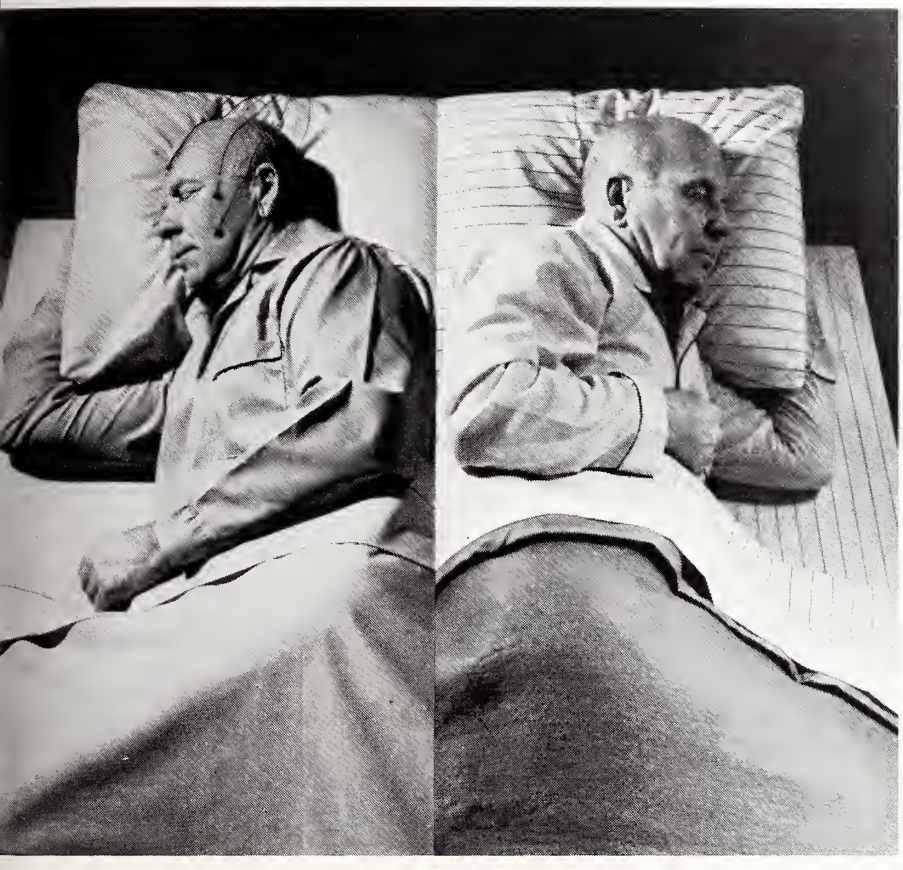
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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

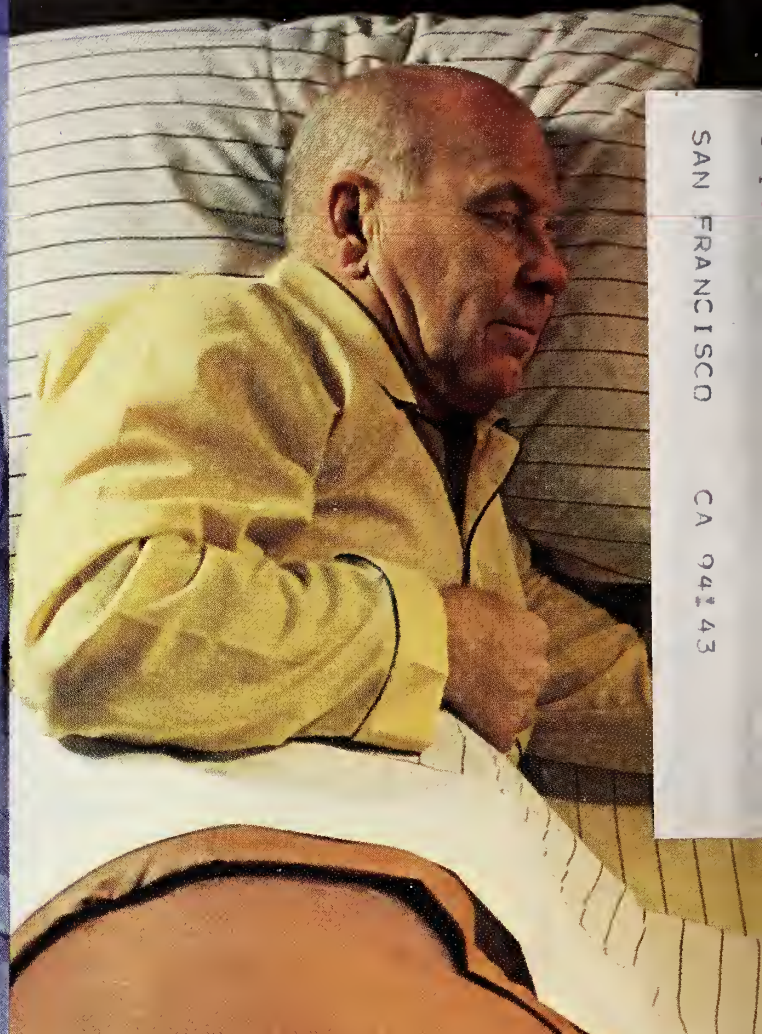
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Volume 86, Number 4, April 1985 ISSN 8755-0059



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THE COVER: Kansas has many lovely faces — such as this one.

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Kansas Medical Society and Auxiliary

The 126th Annual Meeting

May 1-5, 1985 at
THE BRO[A]DMOOR
Colorado Springs, Colorado

REACHING FOR NEW HEIGHTS

Wednesday, May 1

8:00 AM-4:15 PM
Financial Planning Workshop

Thursday, May 2

Sports

Organized Golf Tournament
Tee Times throughout the day
Tennis Tournament
(if adequate response received)

8:00 AM-2:00 PM
The Physician's Role — Medical Ethics in the 80s

11:30 AM-1:00 PM
Joint Luncheon with Auxiliary

4:00 PM-6:00 PM
Welcome Cocktail Reception
University of Kansas Medical Alumni Association

Friday, May 3

8:30 AM-1:00 PM
House of Delegates and Reference Committee

1:00 PM-2:30 PM
Joint Luncheon with Auxiliary

2:30 PM
Continue House if Needed

6:00 PM
Western Steak Fry

Specialty Societies

7:00 AM-8:30 AM
Kansas OB/Gyn Society

Auxiliary

8:30 AM-10:00 AM
Pre-Convention Board

10:00 AM-12:45 PM
General Session

Saturday, May 4

7:00 AM-8:00 AM
Past Presidents Breakfast

8:00 AM-12:00 NOON
The Physician's Role — Medical Ethics in the 80s

6:00 PM-6:30 PM
Installation of KMS President

6:30 PM-8:30 PM
KMS Presidents Reception

Specialty Societies

12:00 NOON-3:00 PM
Kansas Society of Pathologists

12:00 NOON-3:00 PM
Section, Otolaryngology and Head and Neck Surgery

1:00 PM-4:00 PM
Kansas Foundation for Medical Care

Auxiliary

7:30 AM-9:00 AM
Past Presidents Breakfast

7:30 AM-9:00 AM
County Presidents Breakfast

9:00 AM-10:00 AM
Post Convention Board

10:00 AM-12 NOON
Continue Post Convention Board if needed

12:00 NOON-1:30 PM
Auxiliary Luncheon

Sunday, May 5

8:30 AM-12:00 NOON
House of Delegates

12:00 NOON-2:00 PM
Council

Specialty Societies

12:00 NOON-2:00 PM
Kansas Allergy Society

Council Meeting

Report of Meeting held January 19, 1985

The Council convened on Saturday, January 19, 1985 at the Wichita Hilton Inn East, beginning at 9:00 a.m. Those present were:

Carl D. Ambler, M.D.
Franklin G. Bichlmeier, M.D.
F. Calvin Bigler, M.D.
John P. Brockhouse, M.D.
Thomas P. Butcher, M.D.
Francis T. Collins, M.D.
Clair C. Conard, M.D.
Louis M. Culp, M.D.
Jimmie A. Gleason, M.D.
Fredric B. Gnau, M.D.
Donald D. Goering, M.D.
Donald W. Hatton, M.D.
David A. Leitch, M.D.
James A. Loeffler, M.D.
Frank C. Lyons, Jr., M.D.
Warren E. Meyer, M.D.
J. Rand Neuenschwander, M.D.
Lew W. Purinton, M.D.
Edwin D. Rathbun, M.D.
Ralph R. Reed, M.D.
Clifton C. Schopf, M.D.
Richard A. Siemens, M.D.
Richard M. Skibba, M.D.
Newton C. Smith, M.D.
G. Rex Stone, M.D.
Thomas F. Taylor, M.D.
Max E. Teare, M.D.
Linda D. Warren, M.D.
Roger D. Warren, M.D.
Kermit G. Wedel, M.D.
Joel T. Weigand, M.D.

Also present were Val Braun, Gary Caruthers, and Jerry Slaughter.

Agenda

Dr. Bigler convened the meeting and welcomed the members in attendance. Dr. Conard presented the thought for the day. Minutes of the meeting on September 8 were approved.

Mr. Slaughter reviewed the position paper, **"KMS Programs and Staffing,"** which included recommendations for committees, educational services, public relations, representation and legislative advocacy, service to specialty and county medical societies, communication with membership, sources of non-dues income, and staff requirements. The Council accepted the report and approved the following expenditures for 1985: in-office computer system — $50,000; capital improvements — $20,000; professional staff — $15,000.

The **1985 budget** was approved with above inclusions.

Dr. Cherry discussed the importance of a **pre-participation physical examination** for the junior and senior high school athletes. It is recognized that the pre-participation athletic examination is not a substitute for the comprehensive health evaluation or routine health care from the family physician, pediatrician, or clinic. Ideally, a physical examination should be conducted four weeks before participation in sports.

It was agreed that the pre-participation health evaluations for school athletes be utilized as guidelines, not requirements for the physicians to follow, after the discussed modifications are incorporated.

KMS Resolution 84-23 — Alternative Medical Organizations — was reviewed. The Council expressed the consensus that a broad approach be taken; that the public be informed about the prepaid health plans, and that the opinions of AMA and other organizations on such issues be publicized in the *KMS Newsletter* to inform physicians.

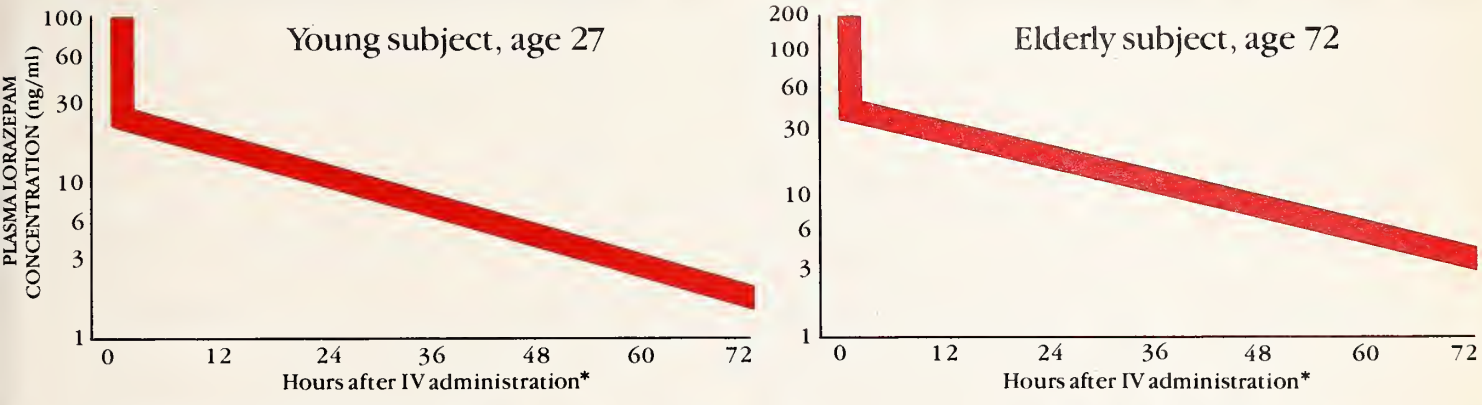
KMS Resolution 84-32 related to physician reimbursement by third party payers. It was reported that since insurance companies' fee schedules, including Blue Shield, are not contingent on KMS action, KMS official endorsement of such fee schedules would not be applicable. The Council noted the physician concerns with coding changes in Medicare and Blue Shield, as well as cost shifting from BC/BS to physicians with no additional reimbursement.

The Council reviewed the following **committee chairmen's reports:**

(Continued on page 110)

Among leading benzodiazepines, only Ativan has proof... pharmacokinetics not significantly altered by age.[1]

Representative charts of comparison testing



Lorazepam is nearly 100 percent bioavailable by the intramuscular and oral routes, as compared to the intravenous. Therefore, data for clearance of intravenous lorazepam are equally applicable to oral lorazepam.



- **Clearance not significantly delayed by age, liver or kidney dysfunction**
- **Cumulative sedative effects seldom a problem**
- **Available in 0.5-mg tablets to facilitate the recommended geriatric starting dosage**

1. Greenblatt DJ: Clinical study, pharmacokinetics and bioavailability in the elderly, Ativan® (lorazepam). Data on file, Wyeth Laboratories.

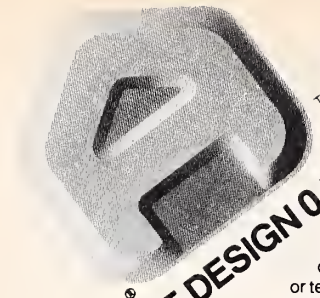
*Fourteen subjects, aged 60 to 84 years, participated in the study. Twelve subjects, aged 19 to 32 years, served as "young controls." Subject dosage was adjusted for body weight and ranged from 1.5 mg to 3.0 mg of lorazepam. Within the study, lorazepam clearance was monitored following IV, IM and oral administration in the elderly group and following IV administration in the control group. The effect of aging on total clearance of lorazepam was relatively small and not statistically significant. Half-life values following the three different routes of administration were essentially identical.

Only Ativan® (lorazepam) IV

Wyeth Laboratories
Philadelphia, PA 19101

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See important information on following page.



The appearance of these tablets is a registered trademark of Wyeth Laboratories.

DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (IV) for (lorazepam) Anxiety

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

HOW SUPPLIED: 0.5, 1.0 and 2.0mg tablets.

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Philadelphia, PA 19101

IMPAIRED PHYSICIAN PROGRAM DIRECTORY

For information concerning the Impaired Physician Program of KMS or to get help for an impaired colleague, yourself or your spouse, please contact the KMS office or the contact person in your area. All information and identities will be held in strictest confidence, and the caller need not identify himself or herself.

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Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).



Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated **widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L39

Potassium-Sparing

DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

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The unique red and white Dyazide® capsule: Your assurance of SK&F quality.

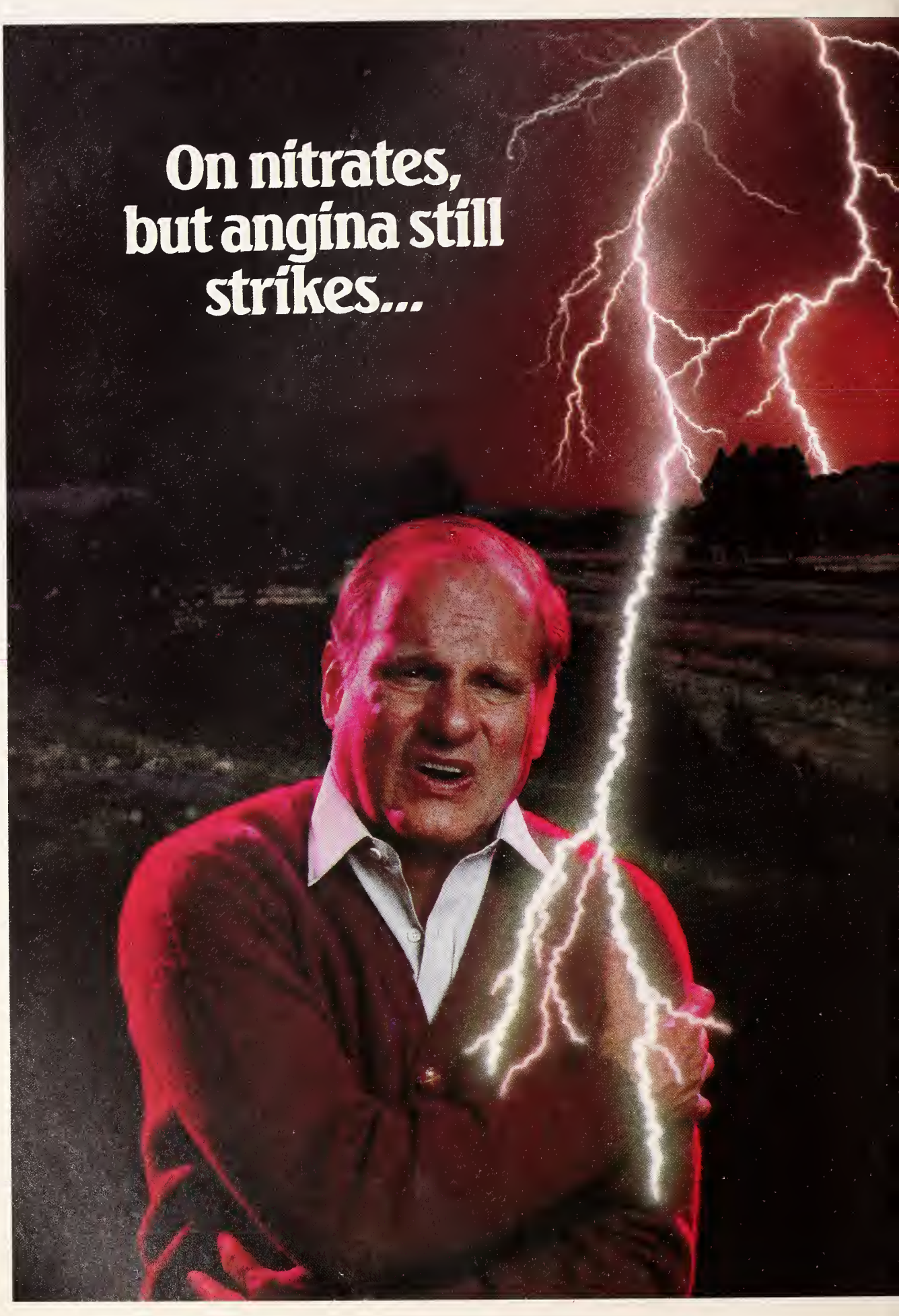


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On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page

ISOPTIN® TABLETS
(verapamil HCl/Knoll)
80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

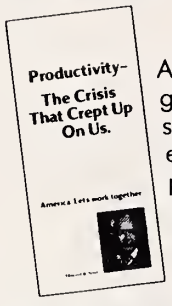
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America's productivity growth rate has been slipping badly for several years now, compared to that of other nations. And it's adversely affecting each and every one of us.

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Council Meeting

(Continued from page 106)

Constitution & By-Laws — Richard M. Skibba, M.D.
Continuing Medical Education — Donald Hatton, M.D.
Drug Utilization Review — Wayne O. Wallace, M.D.
Editorial Board — David E. Gray, M.D.
Governmental Affairs — Franklin G. Bichlmeier, M.D.
Aging — Alex Scott, M.D.
Credentialing — D. W. Bell, M.D.
Health & Environment — Richard Meidinger, M.D.
SRS — Phillip A. Godwin, M.D.
Judicial — Newton C. Smith, M.D.
Impaired Physicians — Ivan E. Rhodes, M.D.
KFMC Study — Thomas F. Taylor, M.D.
Legislative — Erwin T. Janssen, M.D.
Membership/Insurance — Robert Haskins, M.D.
Professional Liability — Jimmie A. Gleason, M.D.
Auxiliary — Ann (John) Rempel
KaMPAC — Roger Warren, M.D.

Council approved an aggressive **marketing program** to recruit out-of-state physicians who hold Kansas licenses. KMS already has an associate membership category for such physicians with a dues level of 50 per cent of regular annual dues.

With none of the bills introduced as of this date, the professional liability and legislative update centered on background information and projections. Insurance Commissioner Bell will appoint an ad hoc commission designed to study medical malpractice in Kansas; "Kansans for Reform" is an organization in Johnson County concerned about the recent sizeable punitive damage suit there; KMS PR project is well underway; physicians are encouraged to itemize their charges to patients, spelling out that portion of service attributable to malpractice insurance cost; the Key Man system was stressed.

Council heard an **update on litigation** in Emporia where several chiropractors have filed suit against the local school board concerning physical examinations.

It was announced that the legal firm providing **counsel to KMS** will no longer represent Kansas Blue Cross/Blue Shield.

KMS was directed to establish a mechanism, similar to AMA Council on Scientific Affairs, to **develop position statements** for public information. (Examples of topics: aspirin and Reyes syn-

drome; chelation therapy; HMOs; PPOs; etc.)

The **1985 Annual Meeting** will be held May 2-5, 1985 at the Broadmoor, Colorado Springs. An optional financial planning workshop will precede the activities on Wednesday, May 1, with Sports Day on Thursday, May 2. The House of Delegates will convene on Friday and Sunday, with Saturday being reserved for the scientific session. Medical ethics is the general topic for the session. The schedule will allow free time for relaxing and enjoying the countryside.

The meeting adjourned at 12:05 p.m.

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Rules of Behavior for Yale Medical Students, Published 1815.

SECTION VII. *Crimes and Misdemeanors.*

ART. 1. Every Medical Student shall be subject to the laws and government of the Medical Institution, and shew, in speech and behaviour all proper tokens of reverence and obedience to the Faculty of the College, as well as of the Medical Institution. And if any Student shall transgress this law, by treating them, or any of them, with reviling or reproachful language; or by behaving contumaciously or contemptuously towards them, or by being guilty of any kind of contempt of their persons or authority, he may be punished by any censure, even to expulsion, as the nature and aggravations of his crime may require.

2. If any Student shall deny the Holy Scriptures, or any part thereof, to be of divine authority; or shall assert and endeavor to propagate among the Students any error or heresy, subverting the foundation of the Christian religion and shall persist therein after admonition, he shall be dismissed.

3. If any Student shall be guilty of Blasphemy, robbery, fornication, theft, forgery, duelling, or any other crime, for which an infamous punishment may be inflicted by the laws of the State, he shall be expelled.

4. If any Student shall assault, wound, or strike, the President, a professor, or a Tutor, or shall maliciously or designedly break their windows or doors, he shall be expelled.

5. If any Student shall be guilty of drunkenness, fighting, striking, quarrelling, challenging, turbulent words or behaviour, wearing women's apparel, fraud, lying, defamation, or any such like crimes, he shall be punished by admonition, or other Collegiate punishment, suited to the nature and demerit of the crime.

6. If any Student shall break open the door of another, or privately pick his lock with any instrument, he shall be admonished or otherwise punished, as the nature of the offence may deserve.

7. If any Student shall be guilty of any injury to a fellow-student, or to any other person within the town of New-Haven, upon complaint and proof thereof made to the President, he shall, with the advice of the Professors, give judgment thereon, and order satisfaction to be made according to the nature of the offence or injury; which, if any student refuse to do, he shall be admonished; and if after admonition, he persist in such refusal, he shall be dismissed.

8. Every Student, in studying time, shall abstain from hallooing, singing, loud talking, playing on a musical instrument, and other noise, in and about the Medical College, or any of the College Buildings.

9. No Student shall keep, or use fire-arms, or gunpowder, in, or near any College Building, or near the person, or dwelling, of any officer of the College.

10. No Student shall stake money, or other property, in any game of hazard, or play at such game at all, within the College Buildings, or within the city of New-Haven, or any Student's room, or keep cards, or any instruments of games of hazard in his chamber.

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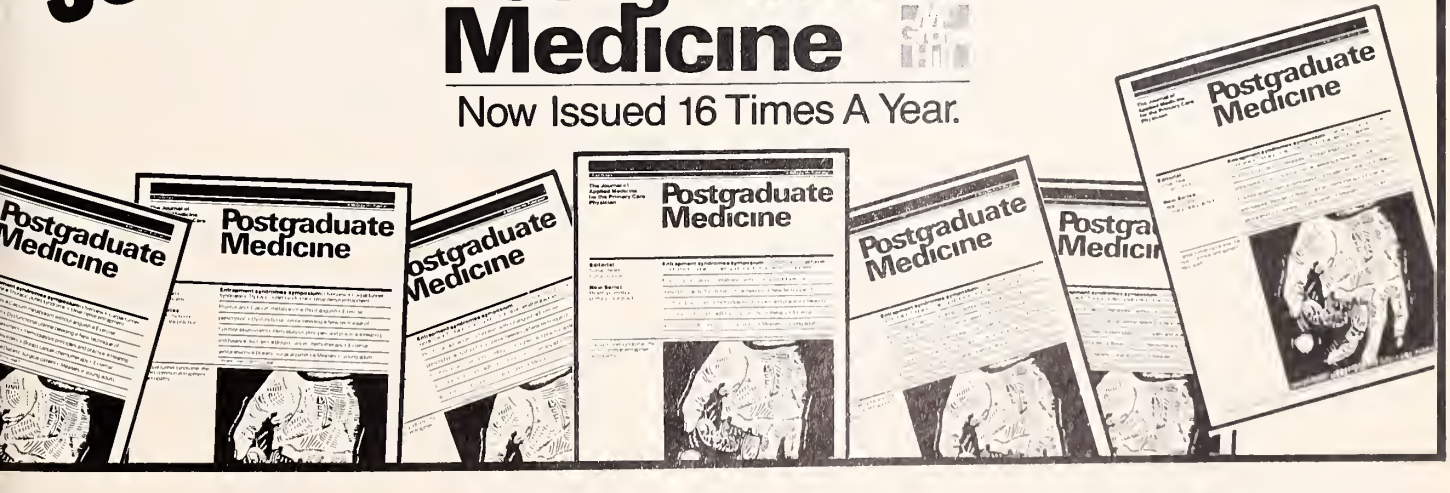
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Physician Responsibility

RICHARD T. FOSTER, J.D., *Wichita*

WHAT ARE the legal responsibilities of a patient's regular physician and of a substitute physician during the absence of the former?

Generally, one physician is not liable for the independent acts of neglect of another unless the latter is an agent or partner of the other. Nevertheless, the treating physician and substitute both owe a legal duty of care to the physician's patients during absence of the regular physician.

Regular Physician's Duties

Responsibilities of the regular attending physician who will be absent from his/her practice include:

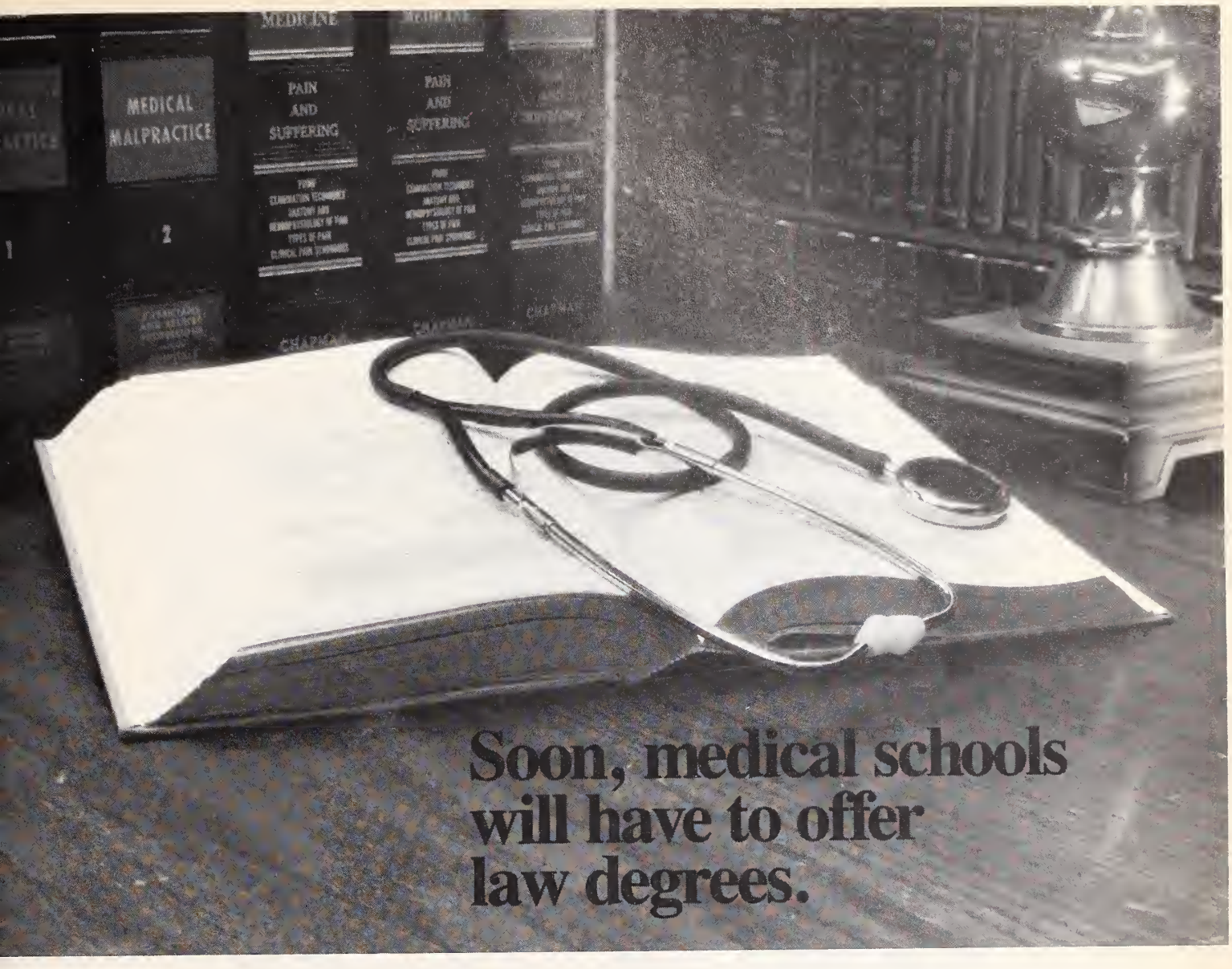
- The physician should arrange for a competent substitute whose training and skills are comparable to those of the referring physician. Ordinary care in the selection of a substitute is important.
- The physician ought always to give adequate instructions to patients under current treatment, to the substitute physician, and to ancillary personnel regarding procedures and treatment that may be required during the physician's absence.
- The absent physician's office staff should be instructed to provide any necessary patient records to the substitute physician. The substitute should know where and how to contact the regular physician at all times, and how to gain access to patient records when the office is closed.

Substitute Physician's Duties

A substitute physician owes patients the same level of reasonable care as is provided to regular patients; the substitute status does not diminish this responsibility.

- The substitute physician should insist that s/he be given the basic information outlined above as well as complete access to any records that might be needed.
- The substitute physician should be willing to personally consult with, physically examine, or obtain records of any patient for whom there is any reasonable doubt regarding proper care and treatment. In appropriate circumstances, referral to another equally competent and skilled physician is an acceptable option.
- In most situations, the substitute physician should not drastically alter the course of treatment without contacting the regular physician. Conservative or temporary treatment of non-emergency conditions may be utilized, depending on the duration of the regular physician's absence.
- The substitute physician should never assume informed consent. The reasons for all treatments, medications, or withholding of them should be clearly explained to the patient. The patient is always free to consult another physician if s/he so chooses.

The responsibilities of the regular attending physician and the substitute overlap to provide continual adequate medical care for all of the former's patients. It is the duty of both physicians to ensure that all information necessary to provide that care is easily accessible to the substitute physician during the regular physician's absence. Having accepted the responsibility, the substitute physician cannot neglect or abandon a patient on the grounds that it is inconvenient to obtain the information necessary for adequate treatment.



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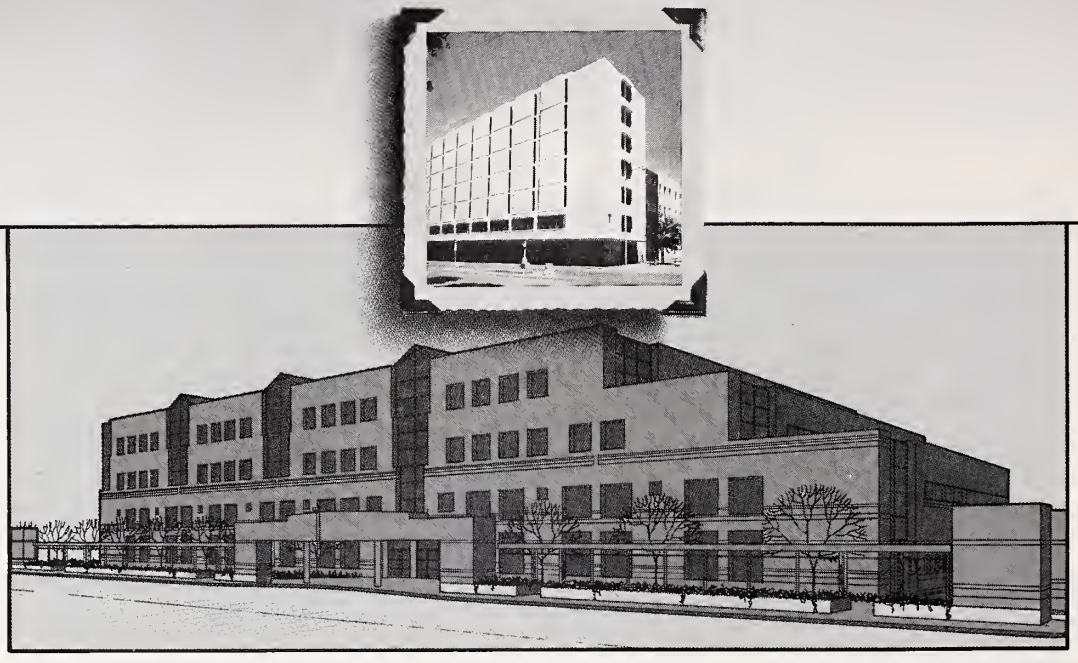
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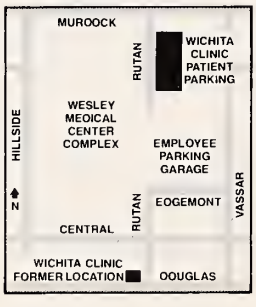
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SCIENTIFIC ARTICLES

Runner's Hematuria

TIMOTHY VOTAPKA, M.D. *and* JOHN W. WEIGEL, M.D., *Kansas City, Kansas*

As the number of runners and joggers continues to increase, so too has the number of running related injuries. Runner's injuries range from fluid and electrolyte imbalance, heat prostration, and stress fractures to acute renal failure and occasionally to death. Gross or microscopic hematuria following distance running is seen occasionally in our clinic, and this review of the literature attempts to delineate the problem and discuss its evaluation and treatment.

The occurrence of hematuria among runners is not new, but with today's emphasis on fitness it is no doubt more frequent than it was in the past. Nevertheless, Brieger[1] points out that as early as 1713 Ramazzini noted that runners sometimes pass bloody urine, and that a medical encyclopedia from the first century A.D. advised runners to discontinue this activity if the kidneys became affected.

Reports of the frequency of hematuria among runners vary widely. In a recent study by Seigel,[2] 18 per cent of 50 post-marathon urinalyses revealed either microscopic or grossly bloody urine. Dancaster[3] reports 70 per cent of 31 runners had red cells in their urine following a 54 mile marathon while Schiff,[4] who studied a group of runners following a somewhat similar marathon, found significant hematuria in 50 per cent of his 44 subjects. Since both distances run and other conditions in these races were variable, a comparison between the studies could not be conclusive. Although such studies are few and the numbers small, the results seem to indicate that the disorder is indeed significant.

Most early writings implicate the upper urinary tract as the site of hemorrhage. Brieger notes Ramazzini's postulation that the bloody urine of runners is due to venous rupture within the kidney itself.[1] A renal origin is well known and accepted for the hematuria arising in boxers and football players. Such hematuria is generally attributed to parenchymal trauma and is associated with changes in urinary sediment, specifically with the presence of red cell casts. Although both forms of hematuria are transient and usually associated with significant proteinuria,[2, 3, 5] the absence of red cell casts in runner's hematuria could argue against similar etiologies.

Dancaster[3] indicates that mild renal ischemia may be contributory to the hematuria seen in long distance runners. Ischemic damage to glomeruli and tubules may increase permeability and allow red cells and protein to be lost to the urine.[6] Kleiman,[7] who studied radiologic changes in post-exercise subjects, attributes post-exertional hematuria to trauma from the kidney impacting against the twelfth rib.

Recent medical opinion seems to have shifted; a lower tract origin is now thought to be the most common etiology for runner's hematuria. Most of these reports name the bladder as the area of hemorrhage, citing the presence of clots and the absence of casts as contributory evidence. Fred *et al*[8] report the bladder neck and posterior urethra as the site of blood loss. Blacklock[6] attributes the bloody urine to "repeated impact of the flaccid posterior wall of the bladder against the bladder base." He studied 18 runners with hematuria endoscopically, and consistently found contusions on the inter-ureteric ridge and on the posterior rim of the internal meatus. He then hypothesized that the natural contraction of pelvic musculature accompanied by the increased intra-abdominal pressures of heavy respirations "will force the surface of the posterior bladder wall into apposition with the trigone," and result in the observed injuries. Siegel[2] postulated that repeated trauma of the posterior bladder against the base of the prostate is the cause of mucosal hemorrhage. This theory would seem to be supported by an absence of reported cases of runner's hematuria occurring in female runners. An occasional female runner presenting in our clinic with complaints of hematuria may indicate that female runners can manifest similar findings.

Reports of successful treatment of those who suffer from true runner's hematuria are few, and even

(Continued on page 129)

Address reprint requests to Dr. Weigel, Section of Urology, UKSM-KC, 39th & Rainbow Blvd., Kansas City KS 66103.

The Cochlear Implant

F. B. GNAU, M.D., *Halstead*

On November 29, 1984, the Food and Drug Administration announced the approval of the 3M Cochlear Implant System (CI) for medical commercial use. The basic research and final development of this system was done at the House Ear Institute in Los Angeles under the guidance of the respected otologist, William F. House. Considerable fanfare attended this announcement, and soon the words "cochlear implant" became media "buzz words," stimulating the imaginations of the media and their audience as the electronic ear that would cure hearing loss. Resultant inquiries to physicians from the hearing impaired, their relatives and friends found many short of firsthand, accurate information. The following summary of the device, its application, and limitations will provide physicians with the necessary information to permit appropriate advice to these patients.

The CI and Its Application

The House design cochlear implant *(Figure 1)* involves an internal and an external unit. The internal, or implanted, part contains a coil and a magnet imbedded in a bioinactive plastic, and the coil's two leads are connected to two platinum electrodes. One electrode is insulated to within six millimeters of its special ball-tipped intracochlear portion and the other electrode is bare. At the time of surgery, the coil is fitted into a machined indentation in the skull above the mastoid process and held securely in place using a special suturing technique. The path for the insulated cochlear electrode is created by performing a simple mastoidectomy and then extending this into the space behind the tympanic membrane by way of a facial recess dissection. The round window is then visualized and the six millimeter tip is inserted through the round window membrane into the scala tympani of the cochlea. The bare electrode is placed in the soft tissue just above the mastoid. Once implanted, this internal part of the system is completely under the skin of the scalp and becomes surrounded by a connective tissue envelope, similar to that which develops around the battery pack of cardiac pacemakers.

The external part of the CI involves a tiny microphone that picks up environmental sounds and can be worn on the clothes as a tie tack or on a hook device over the ear. This connects by way of a small wire to a cigarette-pack size "signal processor" which is worn clipped to the belt or in the pocket of the user. The battery powered electronic circuitry of the signal processor produces a 16-kilohertz carrier wave that is modified by the incoming signal from the microphone. This modified signal is then carried by a small wire to the external transmitter which is held in place over the receiving coil of the implanted device by the attractive force of the magnet in the internal unit. This signal is then transmitted through the skin to the internal coil by induction and subsequently through the electrodes to the remaining neurosensory elements of the patient's cochlea.

In a routine case, the patient spends three to four days in the hospital including the day of surgery. The stitches are removed seven to eight days after surgery. Eight weeks after implantation, the patient begins an intense, time-consuming rehabilitation program in which at least 20 contact hours are spent with a specially trained audiologist who is familiar with the CI and its application. The patient is then seen once every six months after this initial guidance series, and is encouraged to consider the rest of his/her life as an auditory learning experience.

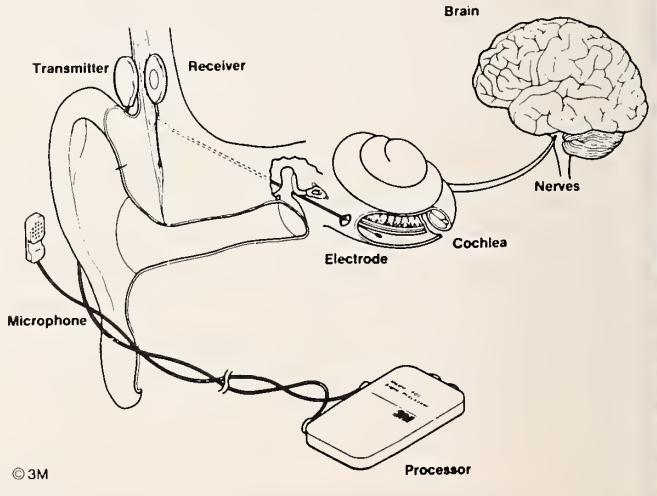


Figure 1. The 3M cochlear implant device.

Address reprint requests to Dr. Gnau, 803 Main, Halstead, KS 67056.

Who Can Benefit?

In reality, the numbers of hearing impaired people who would be candidates for this "first generation" CI are few. Current national statistics suggest that 5.8 per cent of the U.S. population is hearing impaired to some degree. Many of these people's losses are mild to moderate, and rather than seek professional help, they simply make adjustments in their lives to compensate for their hearing losses. The great majority of the remaining group can be rehabilitated by surgery (for those with conductive losses) or by the use of hearing aids (for those with neurosensory losses). Only in those patients whose losses are so profound that they cannot be helped by the above measures can cochlear implantation be considered a reasonable treatment option.

In the final group of profoundly deaf individuals, there are those who have acquired their deafness after the acquisition of language (postlingual) and those who were born deaf or lost their hearing before language acquisition (prelingual). The cochlear implant is not approved for use in children in either the pre- or postlingual categories except in rigidly controlled, investigational settings at seven designated research centers in this country.

This leaves the prelingual and postlingual deaf adults as candidates for the cochlear implant. Those who will perform this kind of surgery have been cautioned to select patients from the prelingual deaf adult population with critical attention focused on the presurgical evaluation of these patients' self-motivation factors. The basis for this cautious approach is related directly to investigational stage statistics which show that approximately one-third of those in this group who had implants became "non-users." This is apparently because these patients were so psychologically reconciled to life in the nonhearing world that the work required to benefit from the CI just was not worth the effort. This leaves mainly postlingual deaf adults as candidates for the CI.

The Postlingual Deaf Adult

The CI has been shown to raise warble tone hearing thresholds to the 55-60 decibel range in the speech frequencies allowing the user to perceive most medium and loud sounds. The CI allows for the recognition of differences in the rhythm and loudness of syllables in words. This, along with the ability to perceive the number of syllables per word, greatly enhances speech (lip) reading skills. It likewise allows the patient to monitor the loudness level of his or her own voice and it seems to help relieve the vexing tinnitus that most deaf patients are burdened with. Implanted patients can likewise perceive and distinguish between such environmental sounds as sirens, car horns, doorbells, telephones and alarm clocks, and as a result they feel more secure. Another point that is mentioned by many of these patients is that the cochlear implant, by providing background environmental sounds, relieves the haunting feeling of isolation that is so troublesome to the deaf. All of the above advantages obviously raise the quality of life for these patients.

Limitations of the CI

The cochlear implant does not allow the patient to understand speech without visual clues. Differentiation of various pure tones below 500 cycles per second (that is, one octave above middle C on a piano) is possible, but above this frequency, discrimination is poor. The spoken word is a complex, multi-frequency message that involves frequencies up to and in excess of 8000 cycles per second. The implant in its current state of development fails to provide a usable breakdown of this high frequency information to the remaining neurosensory elements in these patients.

The cochlear implant does not restore hearing in the same degree or sense that most implanted patients remember before the onset of their deafness. Most of these patients must force themselves to use the device at first, and this early listening experience is not always pleasant. Only when the patient realizes that the CI is a true rehabilitative device can slow, steady progress in utilization be made. Most successful long-term users have the attitude, even after years of daily use, that every new day offers fresh auditory experiences that need to be consciously integrated into their perception of their environment. In short, getting the most out of the CI involves active mental work on the part of the user in contrast to normal hearing which, for the most part, is passive and casual.

The Future

Whether an adult loses his or her hearing suddenly as a result of meningitis, head trauma, or ototoxic drugs or at a more insidious pace as in Meniere's disease or cochlear otosclerosis, the prognosis in the past has been poor. Now there is a treatment option that can help these patients, and those who deal with hearing impairment are grateful for it. Likewise, there is hope for those adults who note progressive

(Continued on page 132)

Outcome: Low Birth Weight Infants

HAROLD J. HENNING, JR., M.D.; BRENT E. FINLEY, M.D. *and* CHARLES R. KING, M.D.,
Kansas City, Kansas

OBSTETRICAL management has improved so dramatically during the past half century that the perinatal mortality rate (PMR) rather than the maternal mortality rate (MMR) has come to serve as the index of the level of obstetrical care.[1] The MMR has continued to drop from about one death per 200 live births in 1935, to about one per 1000 in 1950, to today's level of about one maternal death per 10,000 live births. Reasons cited for this 50-fold drop include such diverse general improvements in medical practice as availability of blood products, new antibiotics, better and more laboratory indices, refined obstetrical training, continuing medical education programs, better facilities, increased access to hospitals and clinics, and the general increase in the proportion of hospital deliveries to home deliveries.

Concomittantly, the PMR has declined from approximately one death per 25 live births in 1950 to the current rate of one per 50. The fetal (stillbirth), neonatal, and infant mortality rates (IMR) have, likewise, decreased about two-fold during the past 30 years. The IMR for all races has been declining steadily during the past decade.[2] The number of stillbirths has steadily declined as prenatal care improved; unfortunately, a large proportion of the intrauterine deaths lack definitive explanation. Only within the past five years have intrauterine deaths (stillbirths) replaced neonatal deaths as the major cause of perinatal mortality. The NMR is currently about one death per 100 live births. One of the major factors in the decline of NMR is the improved survival of the low birth weight infant.[2]

Presented here are current neonatal outcome statistics at UKSM-KC.

Patients and Material

Between February 1, 1982 and January 31, 1983, 240 infants who each weighed less than 2500 grams were admitted to the medical center. Nineteen were not followed here and seven were eliminated from the study due to congenital anomalies not compatible with extrauterine life. A net population of 214 infants is, therefore, included in this study.

Pediatric physicians were in attendance in the majority of the low birth weight deliveries with the major exceptions being those of over estimation of fetal weight or precipitous deliveries. Pediatric gestational age was determined by physical and neurological assessment of the infant via the scoring system of Ballard.[3] Classification of infants (*i.e.* large, appropriate, or small for gestational age) was based on Lubcheno charts.[4]

Results

During the one-year study period, 49 infants (23%) were born to women transferred to UKSM, 24 infants (11%) were transferred to UKSM after delivery, while 141 infants (66%) were born of mothers followed in clinics at UKSM. The infants ranged from 320 to 2499 grams in weight and from 21 to 41 weeks gestational age. Twelve infants were small for gestational age (SGA) according to pediatric evaluation of gestational age. However, 26 infants were SGA when obstetrical gestational age values were used as evaluated by obstetrical history (last menstrual period, initial examination, fetal heart tones with fetoscope, and quickening) and by admission fundal height. Sonography was obtained on all patients to verify gestational age. There were 103 female and 111 male infants. The mean gestational age was 32 weeks and the mean birth weight was 1762 grams. Four infants were LGA by pediatric criteria.

Delivery was accomplished by cesarean section in 82 (38%) of the total infants. Of the 132 infants (62%) who were delivered vaginally, only nine were in the breech presentation.

Mortality. Thirty-three infants (15%) died during the hospital stay — nine within the first 24 hours, ten from the second to the seventh day, and 11 from the eighth to the 28th day of the hospital stay. Three infants died during the 33rd, 44th and 82nd day of the hospital stay.

All infants who weighed less than 751 grams died. Of the 19 infants born weighing 751 to 1000 grams, 14 (74%) survived. Of the five deaths, four were less than 851 grams, leaving ten (91%) survival rate in the 851 to 1000 gram weight group. A 50 per cent

From the Department of Gynecology and Obstetrics, The University of Kansas School of Medicine-Kansas City.

Address reprint requests to Dr. Henning, Dept. of OB/GYN, UKSM-KC, 39th & Rainbow Blvd., Kansas City KS 66103.

KMS

Kansas Medical Society Newsletter

April, 1985

1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

MEDICAL LICENSE RENEWAL TIME

Kansas State Board of Healing Arts will mail license renewal applications on May 1. All licenses expire on June 30, 1985, and must be renewed. The renewal fee remains at $50. If the license is not renewed by June 30, 1985, a 30-day grace period is given. If not paid by August 1, the renewal fee is raised to $75. The license will be cancelled if not renewed by October 1, 1985.

To practice medicine and surgery in Kansas after license cancellation, the applicant must apply for reinstatement. The reinstatement fee is $75. Proof of continuing medical education must then be supplied before the license can again be activated. Any questions concerning these laws can be answered by the office of the Board of Healing Arts, 503 Kansas Avenue, Suite 500, Topeka KS 66603, ph. (913) 296-7413.

MEDICAID TIMELY FILING

All providers of SRS-sponsored services are reminded that claims for such services must be received by EDS Federal within six months of the date the services were rendered. Claims not received within six months will be denied. If you believe your claim has not received due consideration, you have 30 days after the final action taken by the fiscal agent or SRS to file an appeal to an administrative hearing. Such appeal should be directed to: Chief Hearing Officer, Administrative Appeals, State Office Building, 5th Floor, 10th and Topeka, Topeka KS 66612.

Please remember that all records for the Medicaid/MediKan program (medical, financial and invoice) must be kept for a minimum of five years from the date of payment. This requirement applies to both record availability for manual invoicing and computer-generated invoicing.

If payment for Medicaid claims is not received within 60 days, send a copy of the original claim marked "Tracer" in red, to EDS Federal, PO Box 4649, Topeka KS 66604, or call their communications unit: (913) 273-5700.

DISCIPLINARY ACTION REPORTS

State licensing boards will be alerted by the AMA when a physician has had a licensure action taken against him/her in another state. The new procedure will identify physicians who, having been disciplined in one state, may attempt to practice in another jurisdiction where they hold a license.

In This Issue...

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DISCIPLINARY ACTION REPORTS

The AMA will use its computerized physician Master File to speed communications among licensing bodies. Currently, state boards notify the Federation of State Medical Boards in Fort Worth TX of actions against physicians. It is up to state boards to check FSMB publications for records of those actions. The AMA activity is a response to the national movement in disclosures and concerns regarding credentialing abuses.

ASSISTING IN SURGERY

Current Kansas Administrative Regulation 28-34-17(b) stipulates that in those hospitals providing surgical care, in any procedure with unusual hazard to life, there shall be a qualified physician, present and scrubbed, as first assistant. The determination for identifying specific surgical procedures having "unusual hazard to life" is left to the medical staff at each hospital and is incorporated in the policies and procedures of the operation of the surgical service. The Department of Health interprets this requirement to mean that at least whenever a body cavity is penetrated in a surgical procedure, that a qualified physician be present as a first assistant.



The 1985 KMS Annual Meeting will be held May 1-5, at the Broadmoor, Colorado Springs, Colorado. If you have not made your reservations, please call the KMS office (800-332-0156). Among the festivities this year will be the KMS Auxiliary Diamond Jubilee, celebrating the 60th anniversary of the Medical Auxiliary.

Among the Resolutions to be considered by the House of Delegates will be the following:

85-1 Educational Information on Hospital Staff Privileges
85-2 Kansas Foundation for Medical Care
85-3 Provision of Legal and Administrative Services
85-4 Practice of Medicine by Unlicensed Individuals
85-5 DRGs and Medical Staff Privileges
85-6 Hospital Medical Staff Acting "Under the Influence"
85-7 Hospital Medical Staff Joint Ventures
85-8 Conflict Resolution
85-9 PRO Regulation
85-10 Quality Assurance and Peer Review for Hospital Sponsored Programs
85-11 Policy, Management and Health Economics Education for Graduate Physicians
85-12 Unified Membership
85-13 Delegate Allocation
85-14 By-Laws Changes
85-15 Sunset of 1980 Resolutions
85-16 Kansas Obstetrical Society
85-17 Medical School Class Size
85-18 Physician Placement Services in Kansas
85-19 Kansas State Board of Healing Arts Review Committees for Medicine and Surgery, Osteopathy & Chiropractic
85-20 Chiropractic Scope of Practice

Please see Pg. 105 for program schedule of the Annual Meeting. Note: Thursday's program carries 5 hours Category I credit; Saturday - 4 hours, for a total of 9 hours.

DICARE FEE FREEZE

In testimony before the Subcommittee on Health of the House Ways and Means Committee on April 1, HCFA Administrator Carolyne Davis revealed that approximately 4.3% or 13,000 of Medicare's non-participating physicians have been targeted for intensive or month-to-month monitoring of charges by Medicare carriers. Approximately 2% of the total number of non-participating physicians received letters from Medicare carriers within the last month notifying them that they may be in violation of the fee freeze imposed under the Deficit Reduction Act of 1984 and will continue to be subject to intensive monitoring.

DICAL JOURNAL NCLUDED IN DUES

KANSAS MEDICINE, formerly known as The Journal of the Kansas Medical Society, is mailed to KMS members each month. Of the total annual membership dues ($220), $15 is allocated to the magazine, which is now in its 86th year of continuous publication. The Newsletter has now been incorporated as a special section of the Journal for the convenience of the readers and to provide KMS members with a variety of appropriate information as efficiently as possible. Reader comments are always welcome and should be addressed to KANSAS MEDICINE, 1300 Topeka Avenue, Topeka KS 66612.

IA ANNUAL MEETING

Chicago Marriott is the Headquarters for the 1985 meeting. The opening session of the House of Delegates will convene at 2:00 p.m. on Sunday, June 16, in the Grand Ballroom. The closing session will take place on Thursday morning, June 20. Monday will be devoted to Reference Committee meetings. The Kansas Medical Society reception honoring William J. Reals, M.D., Wichita, will be on Monday, 6-8 p.m., in the Chicago Ballroom. Dr. Reals is seeking re-election to the AMA Council on Medical Education.

Kansas Physicians are encouraged to attend the session. If you are unable to do so, please contact your Delegates with any comments or instructions of interest to you. They are:

Delegates	Alternates
Alex Scott, Junction City	Jimmie A. Gleason, Topeka
Lew Purinton, Wichita	Linda D. Warren, Hanover
Kermit G. Wedel, Minneapolis	Warren E. Meyer, Wichita

ATIONAL HOSPITAL EEK

The American Hospital Association has established May 12-18 as 1985 National Hospital Week. This year's theme is LIFEWORK, to describe the dedication and service that are personified in the hospital and its staff.

PHYSICIAN DIRECTORY

Have you introduced yourself to your peers? Call or write the KMS office for details on the new Physician Directory listings now available in KANSAS MEDICINE.

COMMITEE ACTIVITIES

KMS Judicial Committee, chaired by Newton C. Smith, M.D., and the Committee on Impaired Physicians, Ivan E. Rhodes, M.D., Chairman, continue their activities in the impartial and confidential manner. The Judicial Committee reviews and adjudicates complaints against physicians. The IP Committee addresses itself to the problems associated with impairment due to substance abuse.

SPRECHEN SIE DEUTSCH?

In view of the development of modern mass tourism, ADAC (Allgemeiner Deutscher Automobil-Club, The Auto Club of Germany) has set up a file containing names and addresses of German-speaking physicians in different countries. This enables the club to give German tourists spending their holiday abroad the names of physicians in the various specialties to whom they may address themselves when falling ill without having to fear language difficulties. ADAC is the largest motoring organization on the European continent and numbers over seven million members.

If you have German language skills, please contact the Kansas Medical Society. We will then relay the information to ADAC.

FOR THE LIBRARY

Physician Reimbursement Under DRGs: Problems and Prospects discusses the possible extension of Diagnosis Related Groups (DRGs) to inpatient physician services provided to Medicare patients. The volume explores the potential problems with physician DRGs and describes the prospects for such a development. Free from AMA, PO Box 10946, Chicago IL 60610.

American Medicine Comes of Age: 1920-1940 is a 115-page book of 24 essays on issues of ethics, quality of medical education, the founding of the AMA and other socioeconomic, political and legal interests of that period. $9.95 + $2.50 postage from AMA, PO Box 10946, Chicago IL 60610.

The Menopause Time of Life is a prize-winning publication which discusses the signs of menopause, treatments available and tips for maintaining good health through the menopause years. Single copies free from Expand Associates/MENO, 7923 Eastern Avenue, Suite 400, Silver Springs MD 20910.

Handling Patient Telephone Calls Effectively, and Medical Collections are comprehensive, self-contained study courses which include an audiocassette and a workbook. The collection study course includes basic skills for effective communication, how to develop a pleasing phone manner, record-keeping tips, typical reasons for late payments, obtaining specific payment information and standard formulas for incoming and outgoing calls. The telephone course helps the medical assistant professionally handle all types of telephone situations by presenting real-life vignettes of typical calls that come into the medical office. Cost: $30 AMA members; $33 non-members. Order: AMA, PO Box 10946, Chicago IL 60610.

TABLE I
WEIGHT GROUP SURVIVAL DATA

Weeks (Approximate)	*Weight Group (Grams)*	*Died*	*Survived*	*% Survival*
<25	≤750	11	0	0
25-28	751-1000	5	14	74
28-30	1001-1500	10	30	75
30-33	1501-2000	3	48	94
33-35	2001-2500	4	89	96

survival occurred in the 751 to 850 gram weight group. *Table I* expresses weight group survival data. Primary causes of death are presented in *Table II*.

Morbidity. Long term followup studies were not undertaken; however, discharge prognoses were recorded. Those infants with an excellent prognosis numbered 170 (80%), fair or guarded 11 (5%), and 33 died (15%). The overall morbidity and mortality rate was 44 (20%).

Discussion

Selection for intensive care. Ideally, those hospitals that provide maternity care should possess facilities and skilled personnel to administer the most advanced antenatal, intrapartum, and neonatal care possible. Obviously, this is not financially or practically obtainable in today's economically stressed society. As a result, regional Level III perinatal centers have been developed for referral and management of high risk pregnancies and seriously compromised newborn infants. Identification and rapid stable transportation of high risk pregnant patients is, therefore, necessary and should be made generally available.[5, 6]

It is generally accepted that "in utero" transport is more beneficial (*i.e.* a more homeostatic environment) than neonatal transport.[5, 6] However, each situation must be handled individually. For instance, the preterm hemorrhaging or severely pre-eclamptic mother requires stabilization and, if necessary, delivery of the infant with subsequent transport.

Every attempt should be made to transfer infants who no longer require Level III intensive care to intermediate care, Level II, hospitals closer to the homes of transferred mothers. This saves on hospitalization costs, and relieves pressure on the Level III NICU.[7]

Gestational age or weight limit. No infant weighing less than 751 grams survived in this study. Exactly when to begin aggressive management is currently an issue of debate. Mortality statistics have clearly improved with aggressive Level III management of low birth weight infants. Morbidity, although not addressed in this paper, is also a problem currently under investigation. It remains, however, a difficult parameter to quantify.

TABLE II
LOW BIRTH WEIGHT DEATHS

Cause	*Number (N=40)*	*Per cent*
Cardiopulmonary arrest	7	17.5
Respiratory failure	4	10.0
Immaturity (severe)	4	10.0
Cardiac arrest	3	7.5
Cardiovascular collapse	3	7.5
Renal failure	2	5.0
Group B Beta streptococci	2	5.0
Intraventricular hemorrhage	2	5.0
Asphyxic encaphalopathy	2	5.0
Pulmonary hemorrhage	1	2.5
Pulmonary interstitial emphysema	1	2.5
Pneumopericardium	1	2.5
Erythroblastosis fetalis with hydrops	1	2.5
Congenital anomalies not compatible with extrauterine life	7	17.5

A gestational age at which adequate survival statistics warrant aggressive obstetrical management is currently accepted as 27 weeks *(Table 1)*.

Preterm delivery. Prevention, of course, would be the management practice of choice. Understanding the precipitating factors is the first step to obtaining a cure. Identifiable etiological factors in premature (preterm) delivery include those previously described by Arias *et al*:[8] premature rupture of membranes (PROM); preterm labor; maternal/fetal problems (multiple pregnancy, hypertension, abruptio placenta, congenital malformations, placenta previa, incompetent cervix, and others); and iatrogenic preterm delivery.

The diagnosis of preterm rupture of membranes is classically made by the observation of vaginal pooling, nitrazine positive (alkaline) testing, and microscopic viewing of ferning of the amniotic fluid after drying. A firm diagnosis of rupture of membranes is not always easy to make, unless amniotic fluid is grossly seen or felt escaping from the cervical os. Blood will give a false positive nitrazine test. Sonography may be of help by demonstrating interval oligohydramnios. A definitive diagnosis can be made by injecting dye intra-amniotically by transabdominal amniocentesis and observing for vaginal

TABLE III
SUGGESTED MANAGEMENT PROTOCOL

Completed Weeks of Pregnancy	*Ruptured Membranes With or Without Contractions*	*Contractions Only*
25 weeks and less	No tocolytics; no steroids	Tocolytics only
26 and 27	No tocolytics; no steroids	Tocolytics only
28 and 29	No tocolytics; no steroids	Tocolytics; steroids
30 and 31	No tocolytics; no steroids	Tocolytics; steroids
32 and 33	No tocolytics; no steroids	Tocolytics; steroids
34 weeks and over	No tocolytics; no steroids	No tocolytics; no steroids

leakage of the dye material. This invasive procedure should be reserved for those cases in which a diagnosis of PROM will alter the management plan.

Preterm management of labor and ruptured membranes. Infant respiratory distress syndrome (RDS) is a major complication of preterm delivery. The incidence of RDS is inversely related to the infant's gestational age at birth. It is thought to be due to qualitative, as well as quantitative, lack of surfactant production by the Type II pneumocytes of the lungs. The surfactant acts by stabilizing the air-expanded alveoli, lowering surface tension, and thereby preventing alveolar collapse during expiration. Mortality from RDS has declined during the past decade due, in part, to mechanical ventilation and the use of oxygen-enriched air under pressure (continuous positive airway pressure) to prevent the collapse of unstable alveoli. Ventilation and oxygenation are not without their respective complications, however (*i.e.* bronchopulmonary dysplasia, interstitial emphysema, pneumothorax or pneumomediastinum, and retrolental fibroplasia). Therefore, prevention of RDS through enhanced fetal lung maturity is desired, either by (1) increasing intrauterine gestational age; or (2) extrinsic prenatal use of medications such as the currently accepted glucocorticoid therapy and thyroxine amnionic sac injections (which is still experimental). To date, controlled randomized prospective studies utilizing glucocorticoids seem to have demonstrated benefits significant enough to justify glucocorticoid usage in selected patients. Those patients between 28 and 32 weeks appear to benefit provided delivery can be delayed 24 to 48 hours. There are still questions as to the efficacy of steroid usage in PROM.

For prevention of preterm delivery with medicinal therapy, the earliest diagnosis of labor and ruptured membranes is essential. Great interest persists regarding effective treatment regimens for arresting spontaneous labor long before term. It must be stressed that inhibition of labor and increasing gestational age with or without ruptured membranes may not always be in the best interest of the fetus or mother and, therefore, each and every case must be analyzed individually.

The benefits from inhibition of labor have not been overwhelmingly demonstrated and still need to be elucidated. Currently, the β-adrenergic agonist, ritodrine, is being utilized at UKSM with initial inhibition accomplished parenterally. If successful, tocolysis is maintained with the oral preparation until 36 weeks or until maternal and fetal contraindications to its usage present.

Inhibition of labor in patients with premature rupture of membranes (PROM) is especially controversial because of the high risk associated with infection for both mother and fetus. The factor most frequently contributing to perinatal mortality in infants delivered after long term ruptured membranes (greater than 24 hours) is infection.[9]

A schematic approach to the management of preterm labor depending on gestation and state of the membranes is recommended *(Table III).*

Future management possibilities. Research for understanding and prevention of preterm labor and preterm rupture of membranes is needed. Development of good tocolytic agents without side effects for both mother and fetus is necessary. Ideally, tocolysis should be instituted prior to transport of the mother. The safest, most cost effective means of transport must be determined and implemented.

Clinical research projects concerning management practices are ongoing at UKSM and other perinatal centers now, and require public support and understanding for their continuance.

References are available on request from Dr. Henning, Dept. of OB/GYN, UKSM-KC, 39th & Rainbow Blvd., Kansas City KS 66103.

PRESIDENT'S MESSAGE

Of Kiwis and Keas

After I attended the AMA House of Delegates in Honolulu in early December, my wife and I flew far to the south. No, the trip was not a perquisite of my KMS office, but it was certainly worth the time, effort, and expense. New Zealand is a beautiful country. And the people are beautiful, too. What a wonderful place to visit!

My receptionist had copied many articles about the Hawaiian Islands and New Zealand published in the *National Geographic* since 1920, so — instead of spreading bread crumbs like Hansel and Gretel to find our way home — we scattered pages from our references as we flew and read. There are many parallelisms between the Hawaiian Islands and New Zealand, despite separation by thousands of miles — initial human settlement of the islands, the native languages, certain customs, 18th century exploration by Captain James Cook.

I had never crossed the equator before, so was fascinated by the opposite vector of the vortex, the reversed turn of the tendril and backward spiral of the stalk in climbing plants. (I did not get to see the twist of any tornado in the Southland.) It was difficult checking the vortex in the Air New Zealand 747 until I put small bits of paper on top of the water in the wash basin before opening the drain. The results within a hundred miles or so of the equator were capricious.

In New Zealand there are many unique things. A couple of birds deserve mention. The kiwi is a flightless five pound bird that lays a one pound egg. Since New Zealand soldiers adopted the nickname, New Zealanders often refer to themselves as Kiwis. A kea is a parrot-like bird that initially lived on fruits, berries, and seeds — totally non-carnivorous. However, over the years the bird developed a taste for sheep, especially the fat around the kidneys. This beautiful pest is now vigorously hunted because it preys on the main livestock animal of New Zealand. A couple of keas forced us to close the windows when I stopped the car to photograph them in Fiordland near Milford Sound. Enough of the travelogue!

I did not visit New Zealand to see its birds, its beautiful scenery, or even its wonderful people. The purpose of my journey was to study their solution to the problem of patients injured by medical or surgical treatment. The New Zealand Medical Association had arranged four days packed with interviews of officials in the Accident Compensation Corporation (ACC), other government officials, experts in accident liability and compensation, politicians, many practicing physicians, attorneys, trade unionists and businessmen. I spoke at length with the judge who conceived this unique idea for compensating patients for medical misadventure. I talked with people who had initially opposed the plan. I had conversations about the ACC with many New Zealanders — in airplanes, in airports, in shops, in hotels, in restaurants, along streets, and in the countryside — as well as in formal conferences. There is universal awareness of the availability and method of compensation for medically injured patients. *I did* ***not*** *find anyone who is currently opposed to the method for compensating the victim of a medical accident in New Zealand* — even though several admitted they had initially fought against the change.

The ACC provides for compensation for any "personal injury by accident" in New Zealand. The compensation to a victim of "medical, surgical, dental, or first aid misadventure" is just the same as the compensation to a worker injured on the job. This is analogous to how an injury is handled under the Worker's Compensation Law in Kansas. This is a patient-oriented program. When a patient is injured by medical or surgical treatment in New Zealand, prompt attention is focused on correction of medical damages and compensation by income-preserving payments. The trade-off (frequently I heard the phrase *"quid pro quo"*) for giving up the previous "expensive lottery" in the court system with its utilization by only a few injured patients, its long delays, dependence upon the quality and persuasiveness of individual attorneys, its cumbersome procedures, and unpredictable results was repeatedly emphasized to me to involve at least the following advantages of the present administrative system: simple and understandable procedures; nondiscriminatory entry into the system; guarantee of adequate economic protection to *all* citizens; promptness in decisions and settlements; fairness to all; individual consideration to each initial applica-

(Continued on page 126)

EDITORIAL COMMENT

A Backward Glance

Pursuit of an upcoming project for KANSAS MEDICINE led us back to one of our true loves, the *Transactions of the Kansas Medical Society,* and the reminder that our forefathers (and a few mothers) had problems fully as serious to them as ours seem to us. The *Transactions,* as you probably know, parented this journal which, however, required a little cross-pollination from the separate and privately owned *Kansas Medical Journal* and a gestation of at least 33 years to make it.

Then, as now, the profession indulged in a generous amount of self-approval — but not without a degree of obligation. In 1868, after a lengthy "Whereas," it was resolved, "That, it is the high and solemn duty of each medical practitioner . . . especially to become, before the world, perfect patterns (sic) of physical and moral purity, and thus by combining precept and example, cause the human race to seek a higher sphere of usefulness and happiness." But Daniel C. Jones, in his presidential address in 1872, advised ". . . we have but to uphold the cross of common truth, and those skulking knaves who are poisoning the public mind will fall, as did Lucifer, from the very battlements of heaven to the lowest depths of hell." Strong stuff but Tiffin Sinks put it in perspective in *his* 1876 presidential address when he admonished that ". . . it is folly to clamor against those who indulge in vicious practices; for the world ultimately forms a pretty correct opinion of our merits, and I sometimes think we are rather rated above than below our true value."

If preventive medicine is a currently hot item, consider the presidential remarks of Albert Newman who, in 1868, went back to the basics: "The aim of medicine is twofold: 1st, the prevention of disease; 2nd, its cure.

"It is undoubtedly true that the attentions and efforts of our profession have been far too exclusively directed to the solution of the problems connected with the second named object; and that the great and overshadowing importance of the first has not always been sufficiently recognized." And there was no physician glut in those days.

The presence of a few women practitioners in the state produced a sense of uneasiness that this all-male group tried to obscure under a cloak of joviality. It seems to have been a slow day in the 1871 meeting when "Dr. Lanphier said as there was nothing before the society, he would give them something to talk about and thereupon offered the following resolution: *'Resolved,* That no discrimination, simply on account of sex, shall be made in our professional relations or associations with physicians.'

"After a pleasant discussion, engaged in by Drs. Lanphier, Holderman, Linley, Cochran and Logan, and any number of amendments, the whole matter was laid on the table." In any event, in 1872, Dr. Francena Porter of Lawrence succeeded in convincing the Board of Censors that her Alma Mater, Woman's Medical College in Philadelphia, was indeed a legitimate school, and was admitted by a count of 20 to 5.

But in one area there seems to be a change. In 1871, the society, at the behest of the AMA, resolved, "That all contract physicians as well as those bidding for practice at less rates than those established by a majority of regular graduates in the same area be classed as irregular practitioners." And "irregular" in those days was synonymous with quackery.

Treasurers have always had their problems. In 1869, the incumbent, J. L. Prentiss, after reporting a balance on hand of $61 with $54 due in assessments, had the painful task of adding, "I am under necessity of stating, that on or about the 1st of March last, I lost my pocket record which contained a list of those delinquent in the payment of their annual assessment previous to April 15th, 1868, and am therefore unable to make a complete report."

Well, no one ever said that frontier life was easy — and we hope our progeny look back on us as lovingly as we do on them. — *D.E.G.*



SPECIAL FEATURE

Wayne T. Stratton, J.D., KMS Counsel

ELEANOR BELL*

LAWYER isn't a four-letter word. Although the professional liability crisis has stirred dissent between the medical and legal professions, some attorneys are friends of the medical community. Wayne T. Stratton is one of them. He has been KMS general counsel for the past ten years.

Stratton regrets the conflict that has developed between the medical and legal professions and hopes that it can be minimized in the future. "My practice has been directed toward health care law. I find my work with KMS professionally challenging and exciting."

A native of Topeka, Stratton earned A.B. and J.D. degrees from Washburn University. He subsequently served two years as Judge Advocate in the United States Air Force and then returned to Topeka where he is a partner in the firm of Goodell, Stratton, Edmonds and Palmer.

Stratton enjoys his liaison with the law, and admits to few unrelated activities. Nevertheless, he participates in a variety of professional, educational, and civic endeavors. He has been an adjunct assistant professor of law at Washburn University and has served on their Board of Regents. He has also served on the Topeka Board of Education. Currently he is president of the Topeka Bar Association and Vice President of the Kansas Association of Defense Counsel.

Although the law was first described as a "jealous mistress" more than 150 years ago, Stratton finds it still an accurate assessment. He does, however, find time to pursue his love of flying, and he owns an interest in an airplane.

Throughout the critical malpractice years he has guided the KMS through the legal maze toward possible remedies. His research has enabled Kansas physicians to profit from the experience of those in other states and to avoid time-consuming and futile pursuits. He has joined with KMS leaders to construct strategies that not only will alleviate the problems but, more importantly, have a reasonable chance for implementation.



During his ten-year affiliation with KMS, Stratton has endeavored to transcend the professional conflict. His accomplishment is confirmed by the respect and friendship he has earned from Kansas physicians.

* Editorial Staff Writer

PHYSICIAN DIRECTORY

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NORMAN W. THOMS, M.D., F.A.C.S.	VASCULAR SURGERY

MEDICARE ASSIGNMENT ACCEPTED

President's Message

(Continued from page 123)

tion, hearing or appeal; and the low cost of the program. Noteworthy is the fact that the program administration of the ACC cost only 7 per cent of total income in the year ending March 31, 1984.

A patient gives up the opportunity to sue a doctor in exchange for the advantages of the current system which has been in effect for almost 11 years. A patient does not have to sue a doctor to call that physician to task. Each patient has a mechanism to complain effectively about any physician and to call attention to what he or she considers to be poor treatment. This complaint is assured prompt and careful consideration. The physician involved must respond formally to each written complaint from a patient. If the patient is not satisfied with the doctor's response to a non-frivolous complaint, or if the complaint is of serious nature, investigation is mandatory, with resolution which may involve reprimand, formal censure, curtailing of privileges, or loss of license to practice medicine.

New Zealand was an enjoyable experience. It was refreshing to hear this comment from so many of the leaders in diverse fields: "As we look at this matter, *let us consider what is best for* ***all*** *our citizens.*" It also seemed quite appropriate that the center of attention should indeed be the injured patient — how to correct the injury, how to compensate that person for the injury, and how to prevent such a medical accident from occurring again.

F. Calvin Bayley, M.D.
President

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Left to right: Jim Stevens, MSFS, CFP; Sue A. Ware, Attorney; Leonard Cacchio, Accountant; Dave Hokanson, MSFS, CFP.
Principal *Principal*

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Runner's Hematuria

(Continued from page 117)

these are based upon what is, at best, circumstantial evidence. Bassler touts the benefits of beer in preventing runner's hematuria and prescribes one litre of beer for every twenty kilometers to be run.[9] Fred *et al*[8] describe an association between the lack of animal protein in the diet and the appearance of bloody urine following distance running. In one runner who previously had manifested numerous episodes of runner's hematuria, one serving per day of fowl, fish, or beef was accompanied by the absence of bloody urine. As few as three days without animal protein led to the appearance of exercise-induced hematuria. Blacklock[6] advocates running on a partially filled bladder in order to provide "a hydrostatic cushion, preventing the apposition of the posterior bladder wall and the trigone."

Although this suggestion may be less acceptable to competitive runners, Blacklock's recommendation is nevertheless valuable, and seems physiologically sound.

The extent of medical workup required by these patients is controversial. All clinicians agree that painless hematuria is a worrisome sign indicating potential serious disease including malignancy. When hematuria follows distance running, however, it often is of a benign nature. Dancaster advises those who have "frequent" hematuria "to stop severe exertion as permanent renal damage could occur."

A more reasonable approach is suggested in the reports of Siegel and Fred *et al*. Each case must be fully evaluated individually with a thorough history and physical. It is reasonable that all patients should receive blood counts, BUN and creatinine determinations, and urinalyses. The presence of any associated signs or symptoms such as urinary sediments including red cell casts, fever, weight loss, flank pain, fatigue, abdominal mass, or elevated blood pressure would mandate execretory urography and panendoscopic examinations at the very least.

As the runner population increases, so will the number of runner's hematuria cases. A knowledge and understanding of this disorder will, it is hoped, lead to quicker diagnosis and treatment. Runners should be encouraged not to ignore the presence of bloody urine or any other abnormal finding. The medical workup required will likely be brief but is nevertheless necessary.

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References

1. Brieger GH: The diseases of runners: A view from the eighteenth century — A commentary. *The Pharos*, Fall 1980.
2. Siegel AJ *et al:* Exercise-related hematuria: Findings in a group of marathon runners. *JAMA* 241:391-392, 1979.
3. Dancaster CP, Whereat SJ: Renal function in marathon runners. *S Afr Med J* 45:547-551, 1971.
4. Schiff HB *et al:* Myoglobinuria, rhabdomyolysis and marathon running. *Q J Med* 188:463-472, 1978.
5. Editorial: The haematuria of the long-distance runner. *Br Med J* 2 (6183):159, 1979.
6. Blacklock NJ: Bladder trauma in the long-distance runner: "10,000 meters haematuria." *Br J Urol* 49:129-132, 1977.
7. Kleiman AH: Athlete's kidney. *J Urol* 83:321-329, 1960.
8. Fred HL, Ethan AN: Grossly bloody urine of runners. *South Med J* 70:1394-1396, 1977.
9. Bassler TJ: Beer as prevention for runner's haematuria (Letter). *Br Med J* 2(6200):1293, 1979.

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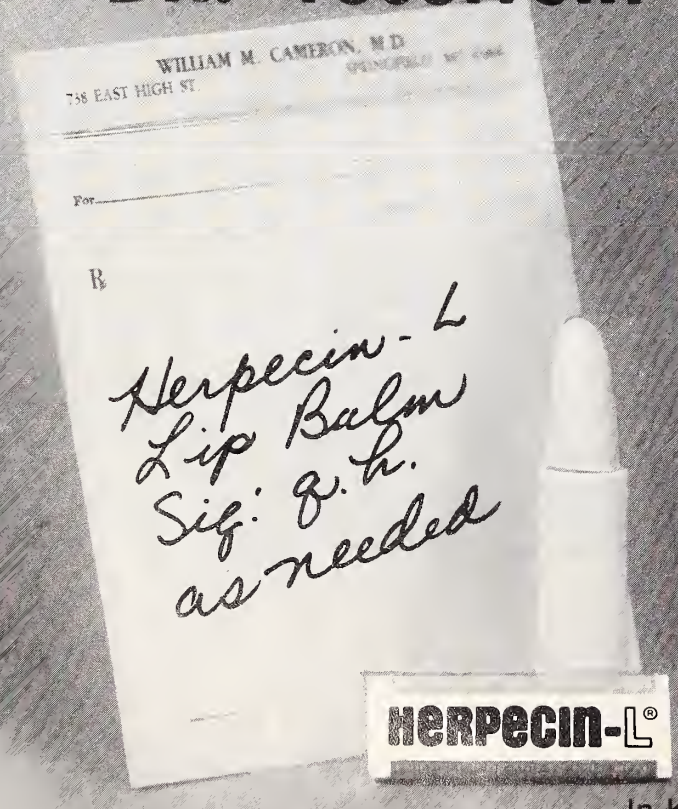


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(Continued from page 119)

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Conclusion

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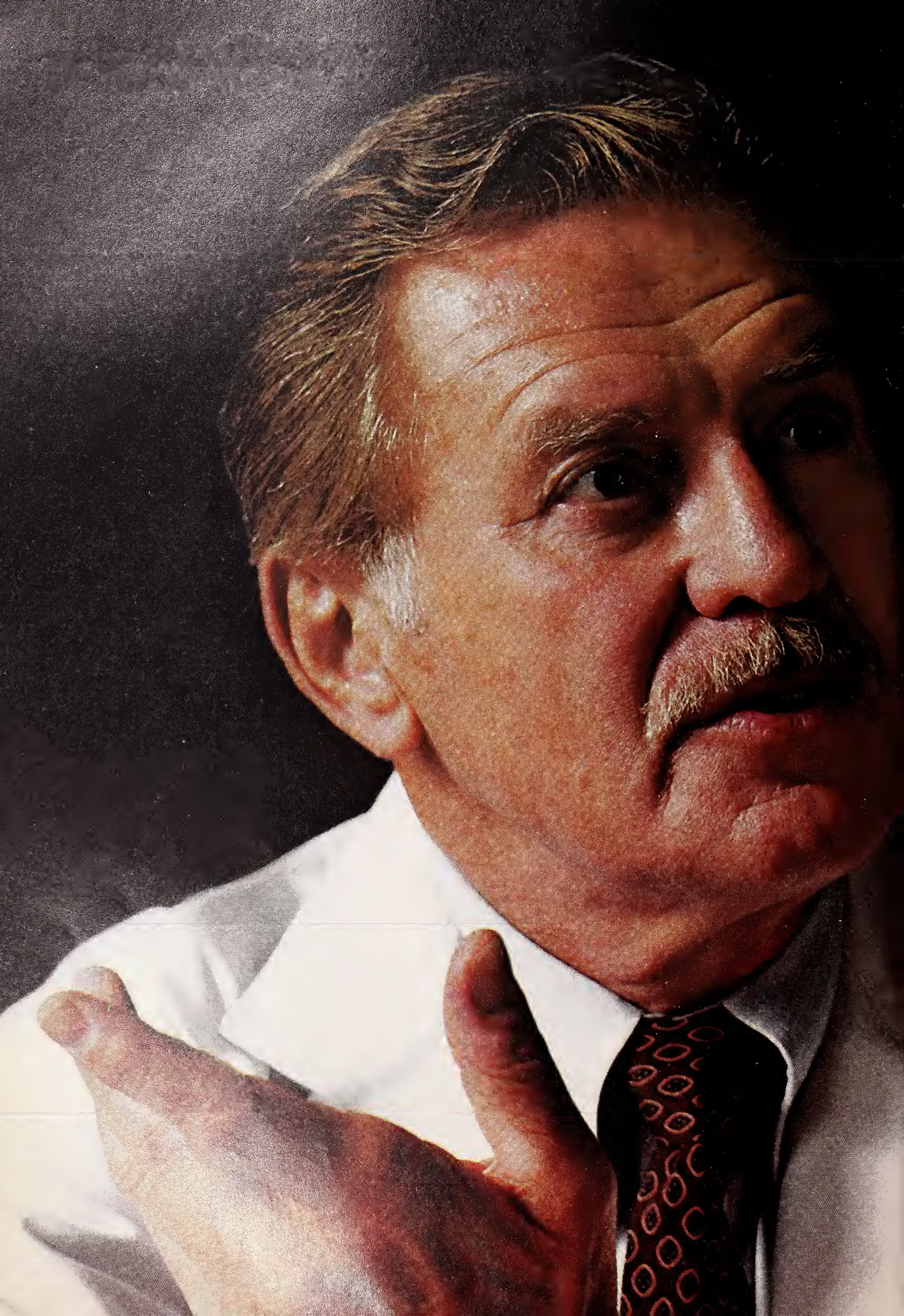
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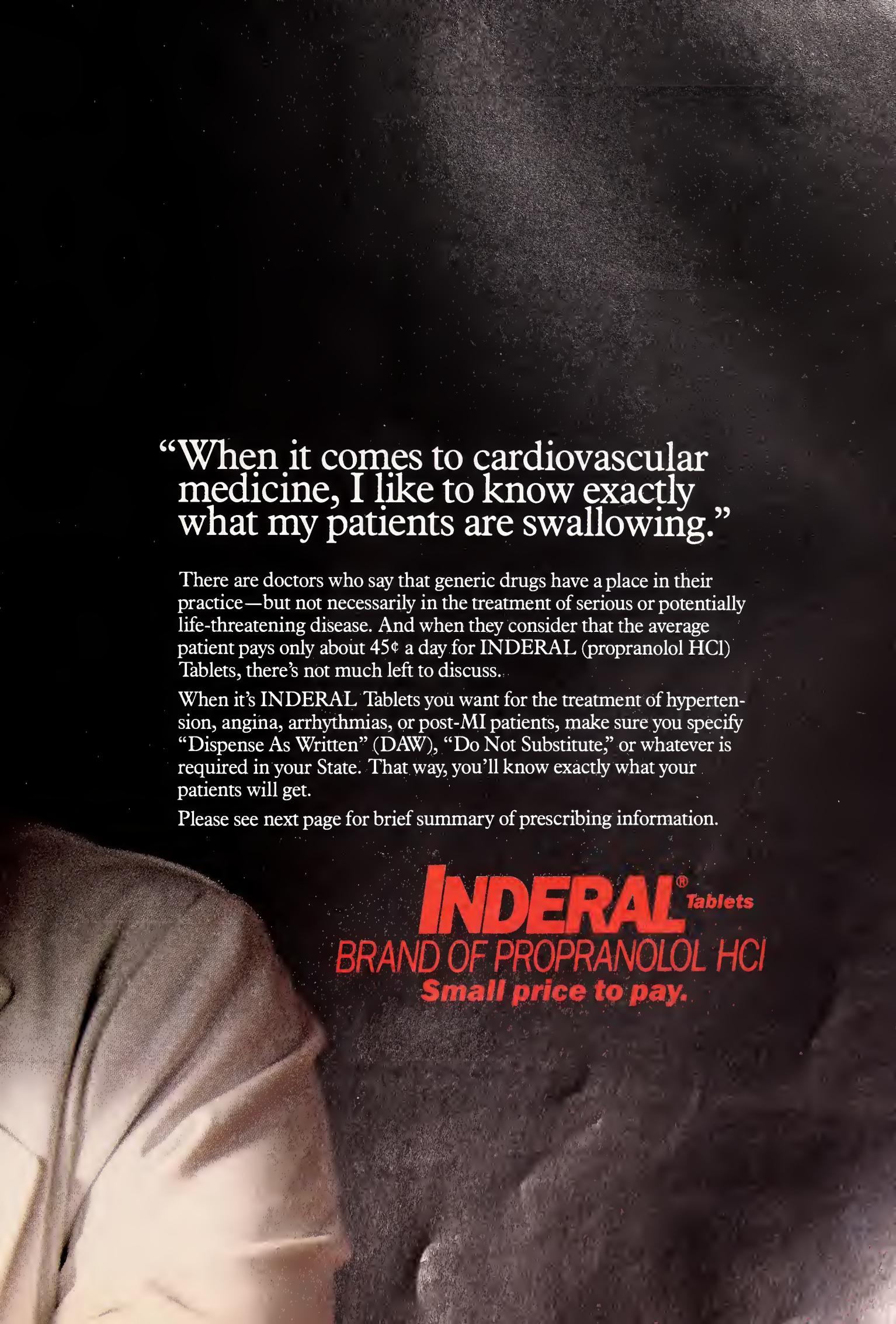
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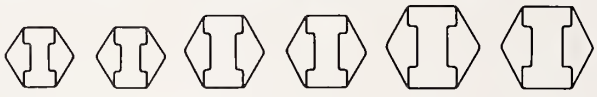



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CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL (propranolol hydrochloride) may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

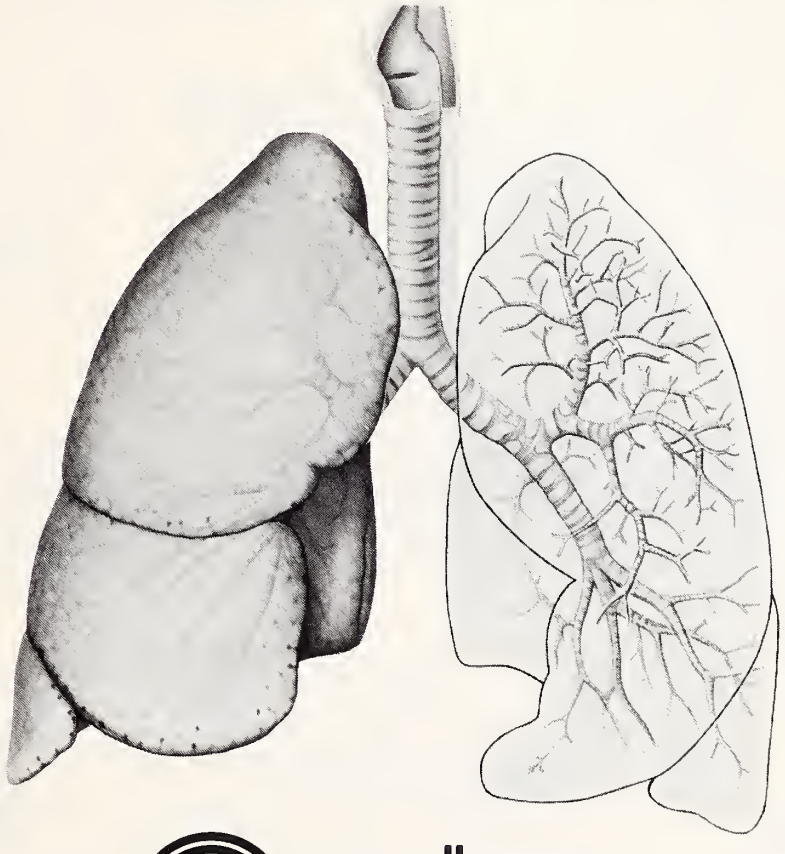
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Brief Summary: Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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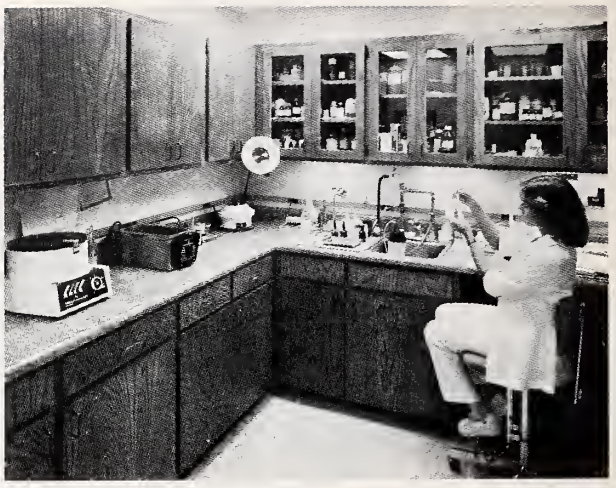
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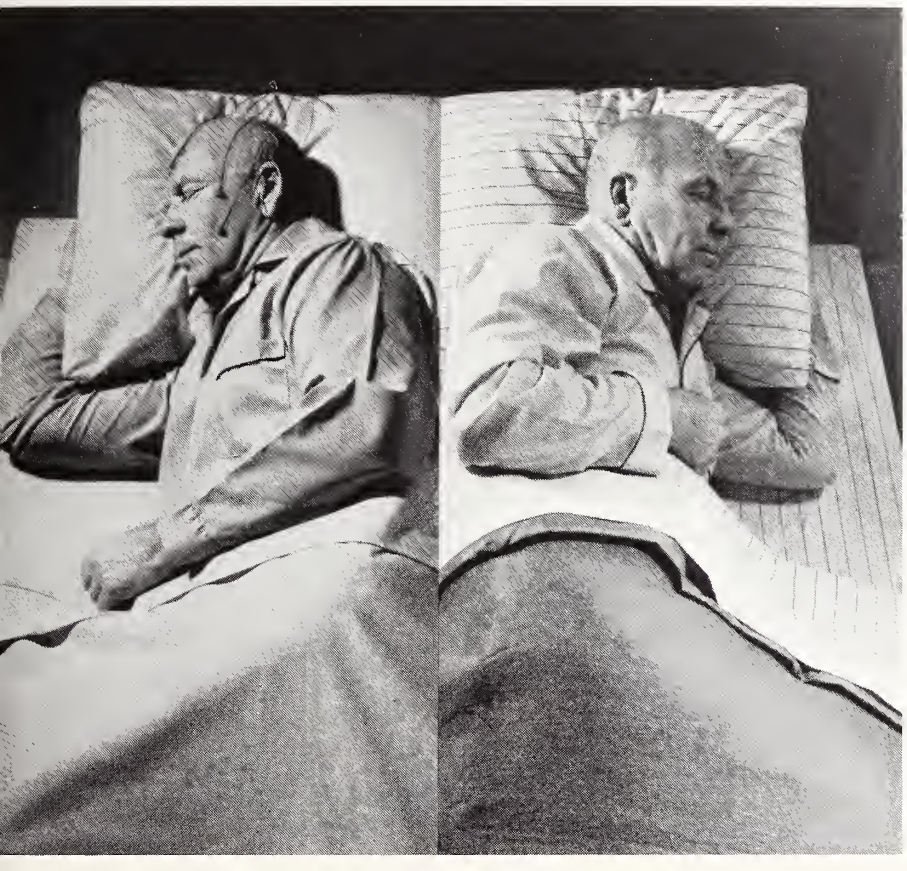
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References: **1.** Kales J *et al*: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther* 18:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther* 19:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther* 32:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology* 26:121-137, 1983.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

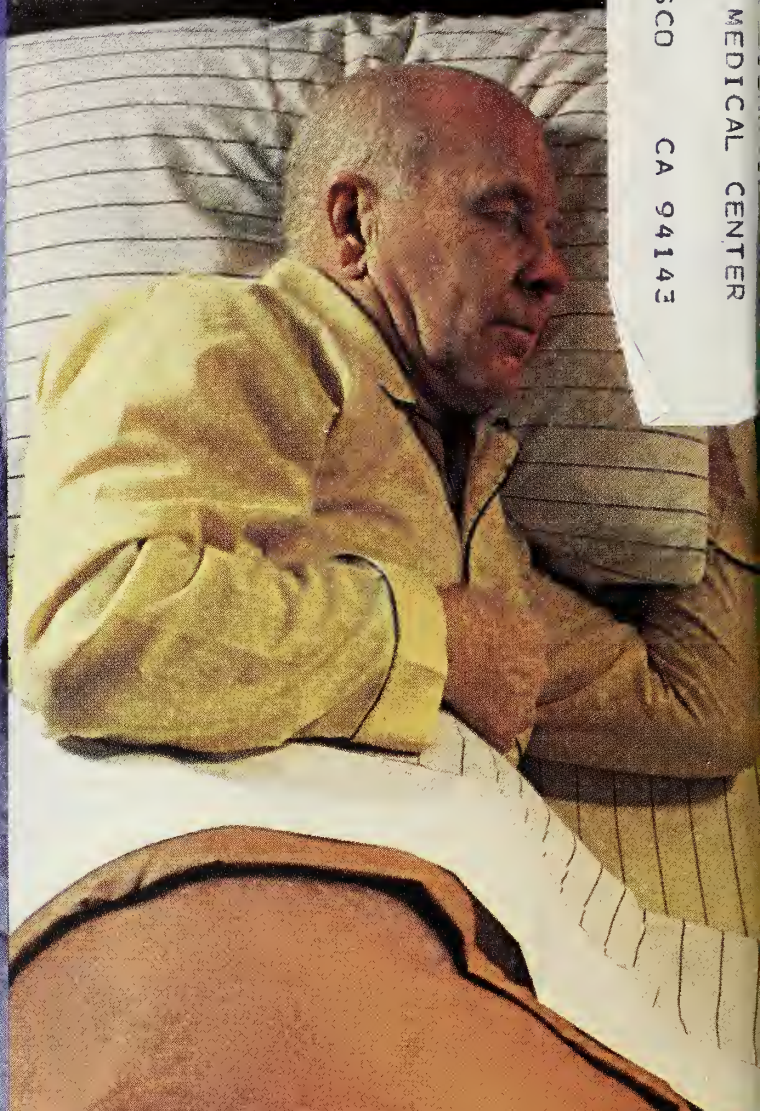
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KANSAS MEDICINE

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KANSAS MEDICINE

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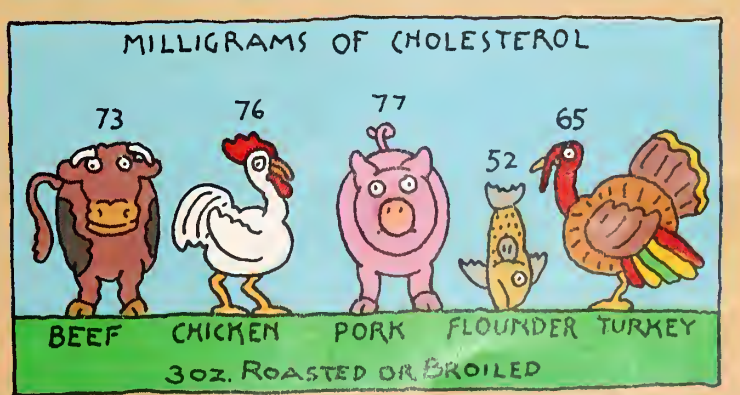
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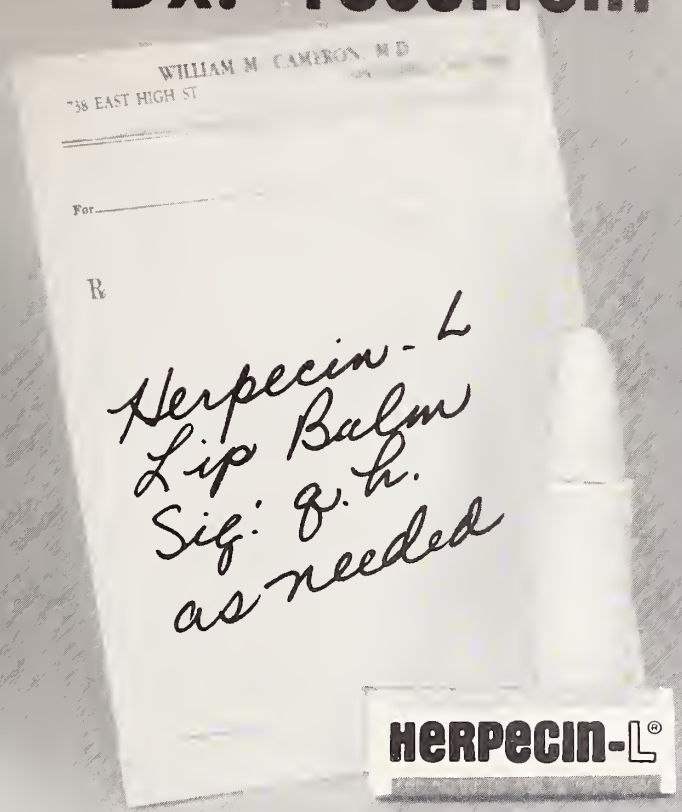
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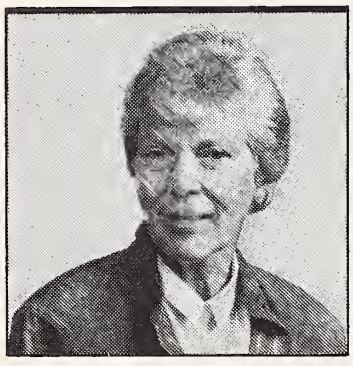


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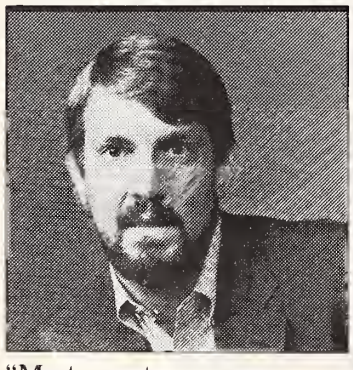
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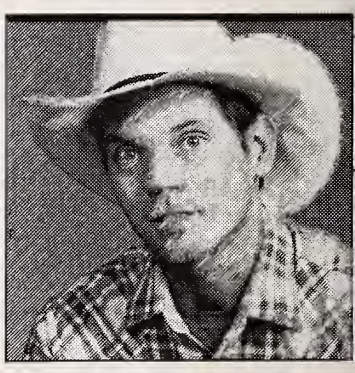
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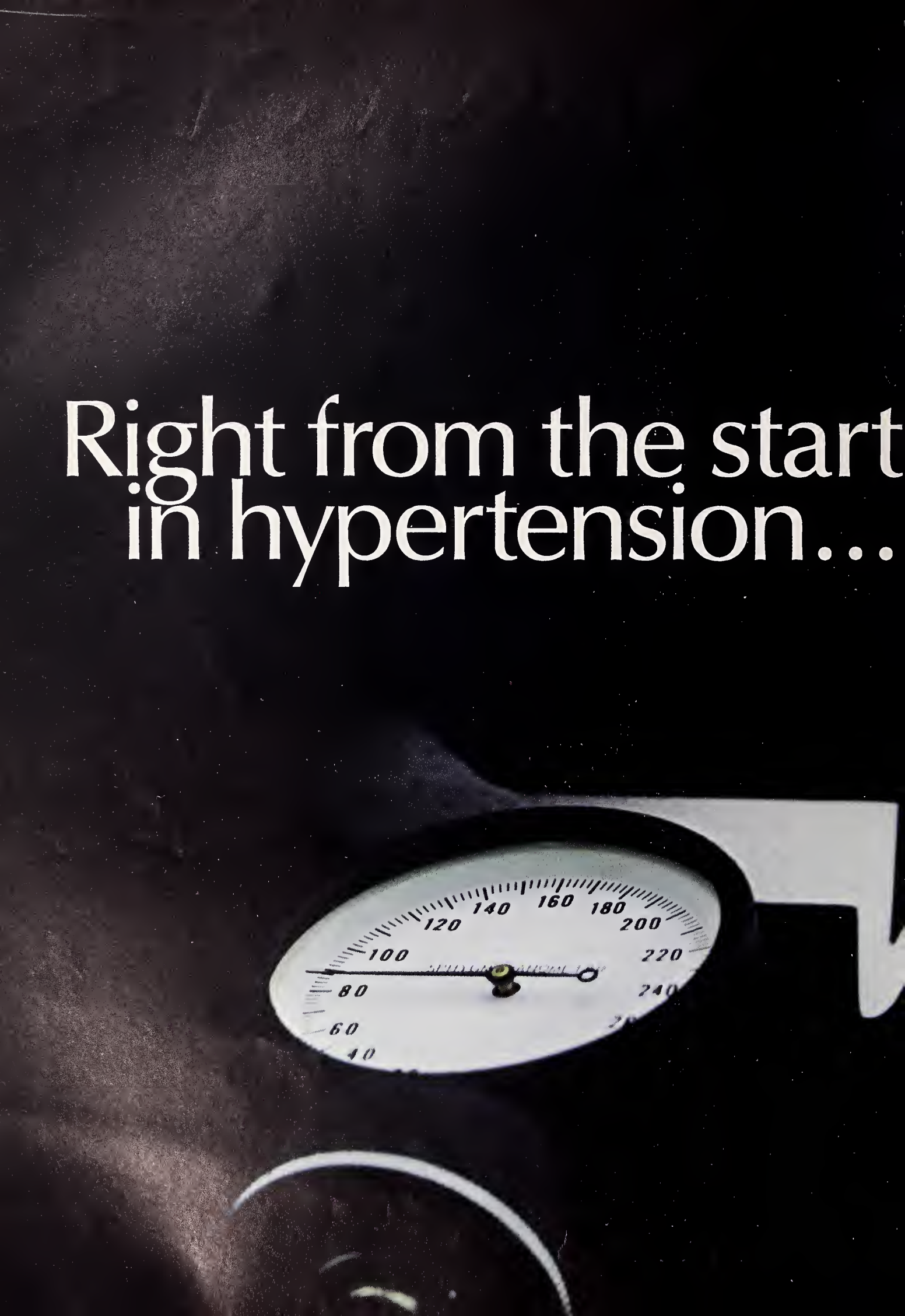
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Please see brief summary of prescribing information on the next page for further details.

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of symoathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

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Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

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Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

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HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

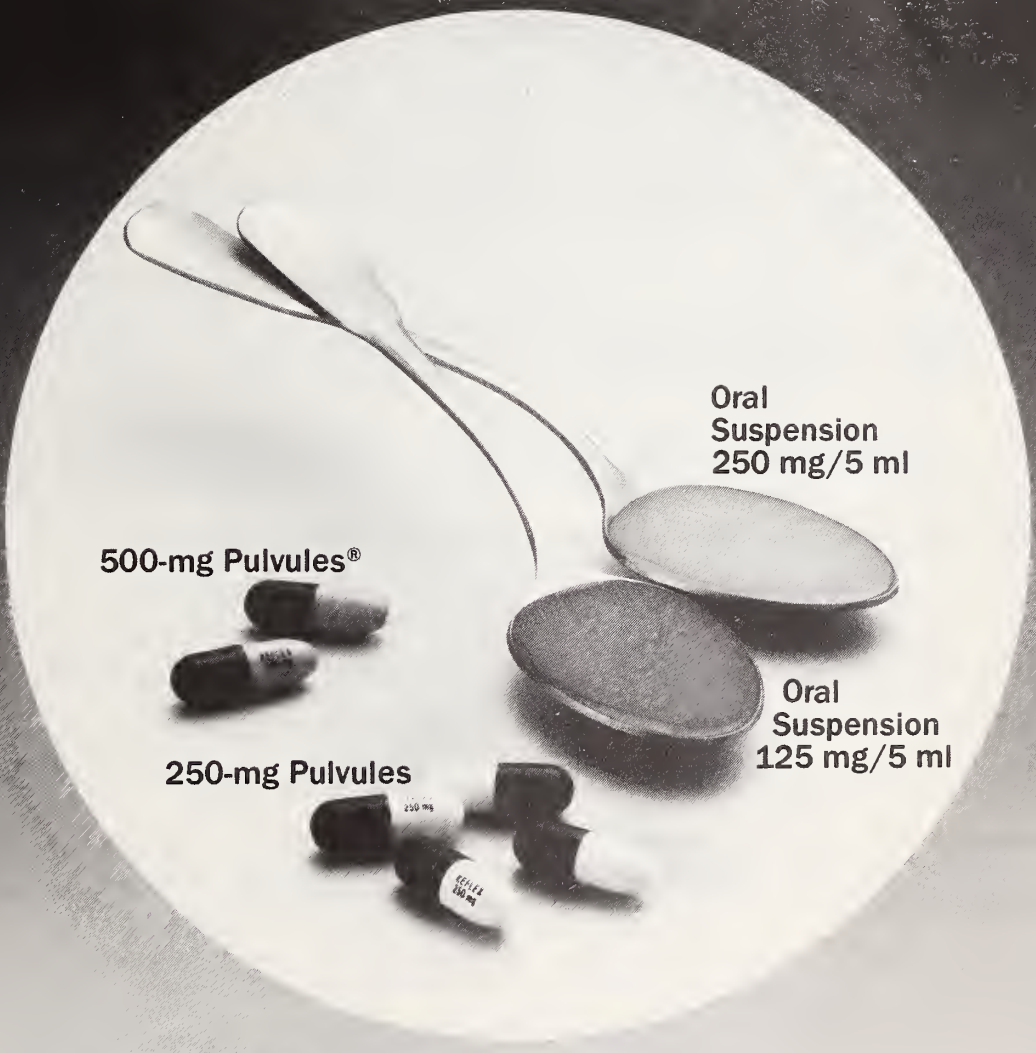
1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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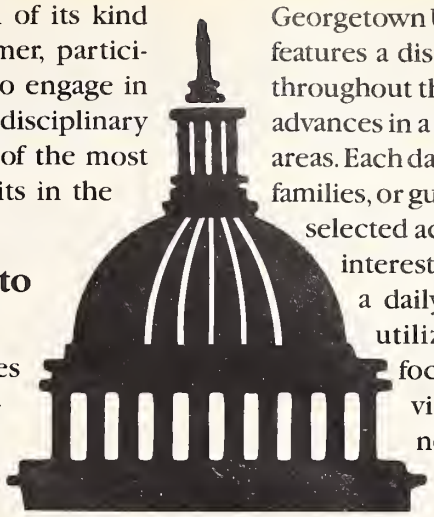
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SCIENTIFIC ARTICLES

Primary Hyperparathyroidism

RANDALL W. WHITCOMB, M.D. *and* **BARBARA P. LUKERT, M.D.,** *Kansas City, Kansas*

PRIMARY hyperparathyroidism (1° HPT) is not a rare disease. A recent study indicates that the annual incidence of this disease is 28/100,000 for the general population.[1] The highest incidence — 188/100,000 — is in women 60 years of age and older; for men 60 years and older, the incidence is 92/100,000. The morbidity of the disease expressed as nephrolithiasis, nephrocalcinosis, bone demineralization, and renal failure is serious enough to warrant early detection and treatment.

We reviewed retrospectively 66 patients with pathology proven 1° HPT seen between 1976-1983 at the University of Kansas Medical Center. Our interest was in analyzing the clinical and laboratory spectrum of the disease as well as evaluating the usefulness of pertinent diagnostic tests.

Patients and Methods

All 66 patients with 1° HPT cited in this study underwent diagnostic evaluation and surgical exploration at UKSM. To be included in the study, patients were required to have normal creatinine clearance and to have undergone all the laboratory and radiologic procedures we were examining. In addition, surgical exploration must have identified either an adenoma or hyperplasia of three or more glands.

Serum calcium determinations were performed using the Technicon Autoanalyzer (Technicon, Inc., Tarrytown, N. Y.). Serum and urine phosphate determinations were also done on the Technicon Autoanalyzer by the method of Fiske and Subbarrow.[2] Percent tubular reabsorption of phosphate (TRP) was calculated using the formula: %TRP = 1 − (phosphate clearance/creatinine clearance) × 100. Patients were required to drink 1 quart of milk daily for three days prior to the measurement of TRP in order to assure adequate phosphorus intake. Immunoreactive N-terminal parathyroid hormone (PTH) levels were determined by the method of Stanbury and Lumb.[3] The T ½ of human PTH measured by this assay system is 7.5 minutes.

Mid-molecule measurements were performed using antibody obtained from Immuno Nuclear Corporation (Stillwater, MN). This antibody does not react with the N-terminal fragment.

Results

Clinical Manifestations (Table I)

Among the patients studied there was a female : male ratio of 2 : 1. Mean age of the group at the time of diagnosis was 54 years.

The mode of presentation was highly variable with the most common being asymptomatic hypercalcemia detected on routine screening in 44% of the patients. Twenty-one percent presented with renal stones as their chief complaint, 15% with weakness and fatigue, 10% with gastrointestinal symptoms, and 5% with bone pain. A few patients were from families with known MEN I syndromes being examined at regular intervals for hypercalcemia. A total of 30% of patients admitted to a history of renal

TABLE I
CLINICAL MANIFESTATIONS & RADIOGRAPHIC FINDINGS

Presenting Complaint (%)	
Asymptomatic hypercalcemia	44
Renal stones	21
Weakness and fatigue	15
GI symptoms	10
Bone pain	5
MEN history	3
Other	2
X-ray Findings (%)	
Negative	48
Generalized demineralization	27
Nephrolithiasis	21
Arthritis	2
Sub-periosteal resorption	2

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TABLE II
LABORATORY DATA

	(Mean ± SEM)		
High serum calcium (mg/dl)	12.4 ± 0.1		
Low serum calcium (mg/dl)	11.0 ± 0.1	(53%	<11.0)
Serum phosphorus (mg/dl)	2.2 ± 0.1	(91%	< 2.2)
24 hour urine calcium (mg)	343 ± 24	(30%	< 250)
TRP (%)	69 ± 1	(80%	<75%)

stones. Interestingly, four of the patients with radiographic evidence of nephrolithiasis were asymptomatic.

Forty-one percent of the patients were on no medications at the time of diagnosis. Thiazide diuretic was the most common medication, taken by 24% of the patients. Eleven per cent were on thyroid hormone; antacids and estrogens were each taken by 8% of patients. Mean blood pressure of the group was 140/83.

Laboratory Findings (Table II)

Multiple serum calcium determinations were performed on each patient. The mean of the highest calcium level in each patient was 12.4 ± 0.1 mg/dl (± SEM) and the mean of the lowest calcium level was 11.0 ± 0.1 mg/dl. The upper limit of normal for our laboratory for serum calcium is 11.0 mg/dl. Of patients studied, 53% had at least one serum calcium level < 11.0 mg/dl, and 26% had values < 10.5 mg/dl.

The mean urinary calcium excretion was 343 ± 24/mg/24 hrs. Thirty percent of patients had calcium excretions <250 mg/24 hrs, with 45% excreting <300 mg/24 hrs. The mean serum clacium 72 hours postoperatively was 8.8 ± 0.1 mg/dl.

Similarly we looked at serum phosphorus levels and TRP. Mean serum phosphorus was 2.2 ± 0.1 mg/dl with 91% of patients having values <2.8 mg/dl. Mean TRP value was 68% ± 1% with 80% of the individuals having a TRP of <75%. There was a significant negative correlation between TRP and serum PTH values ($r = -.46$, $p = 0.01$).

Serum PTH levels were obtained preoperatively in all patients. These assays were done with either N-terminal or mid-molecule antibody, depending on the year the patient was evaluated. Thirty of the patients studied had PTH determinations performed using the N-terminal method. Mean value was 335 ± 25 pg/ml with normal being 200 pg/ml. Seventy percent of the individuals had values <200 pg/ml. An additional 15% had levels <100 pg/ml in the presence of hypercalcemia, bringing the total number of patients with inappropriately elevated PTH levels to 85%. The remaining 36 patients had determinations done using the mid-molecule assay. Mean value in this group was 1.4 ± 0.11 ng/ml with normal being <1.0 ng/ml. Ninety-five percent of patients had values <1.0 ng/ml. The negative correlation between the PTH and TRP values was significant, as previously mentioned.

Radiographic Findings (Table I)

All patients had radiologic evaluation with chest x-ray, abdominal films, excretory urograms, and hand films. Forty-eight percent of patients had negative radiographic surveys. Generalized demineralization was the most prevalent finding, present in 27% of the patients. Only 11% of these patients were men. All women with demineralization were over 50 years of age. Nephrolithiasis was found in 21%, arthritis in 2%, and sub-periosteal resorption in 2%.

Anatomic Location

The diagnosis of hyperplasia was made in 9% of patients with adenomas being found in the rest. Sixty-two percent were found in the inferior glands, 22% in the superior glands, 2% in the mediastinum, and 5% in other locations including the supraclavicular area and within the thyroid gland.

Discussion

The mode of presentation of patients with 1° HPT has changed during the last 10-15 years from symptomatic nephrolithiasis to asymptomatic hypercalcemia discovered on routine laboratory screening.[4] Clearly, the advent of automated techniques has increased our ability to be alerted to hypercalcemia early in the course of the disease. This is perhaps the reason for the perceived change in the presentation of 1° HPT. Fifteen percent of our patients presented with only weakness and fatigue. Although these symptoms are usually thought to be associated with markedly elevated serum calcium levels, the majority of these patients had serum calcium levels in the 10.5-12.5 mg/dl range. Bone pain is an uncommon presentation, found in only 5% of our patients.

Our findings would support the fact that 1° HPT occurs largely in healthy individuals. Forty-one per cent were on no chronic medications, and 48% had no detectable radiographic abnormalities at presentation. As many studies — including this one —

have demonstrated, this is a disease found predominantly in women between 45 and 70 years of age.[5] It is also of interest that the most common radiographic abnormality detected in our patients was generalized demineralization. Eighty-nine percent of patients with this finding were women over 50 years of age. The accelerated bone loss seen in women in this age group without 1° HPT is significant. Clearly, this disease compounds the problem and puts these women at increased risk of developing the complications and morbidity of bone problems including osteoporosis.

The laboratory and radiographic evaluation of patients with suspected 1° HPT has been an area of confusion. It is important to realize that serum calcium levels can fluctuate during the day, possibly related to episodic release of PTH.[6] Fifty-three per cent of our patients had at least one serum calcium level within normal range. Isolated elevation of calcium levels should not be ignored nor considered spurious, and further investigation is obligatory. We currently recommend that patients in whom the diagnosis of 1° HPT is suspected should have at least three serum calcium levels drawn.

The most commonly neglected and perhaps most important laboratory test in these individuals is the serum phosphorus level. PTH inhibits tubular reabsorption of phosphorus by the kidney leading to phosphaturia and hypophosphatemia. Other causes of hypercalcemia except 1° HPT and some tumors with humorally mediated phosphaturia are not associated with a low serum phosphorus level because PTH secretion is reduced by the high serum calcium. We found more than 90% of our patients had a serum phosphorus level <2.8 mg/dl. This is very helpful in making the diagnosis and in separating out other causes of hypercalcemia. TRP can be a useful adjunctive test if conducted properly as 80% of patients studied had values <75%. Phosphate loading — preferably with a quart of milk daily for three days — should be done before the test is performed. We demonstrated a significant negative correlation between PTH and TRP values again showing this test to be a useful measure of PTH action at the kidney.

Urinary calcium measurement is a necessary part of the evaluation, primarily to exclude the rare entity of hypocalciuric hypercalcemia and the necessity for surgical exploration. A calcium/creatinine clearance ratio <0.01 should suggest the possibility of this diagnosis. Hypercalciuria is certainly not a constant feature of 1° HPT with 30% of the patients we studied having values <250 mg/24 hrs.

Serum PTH measurements continue to be a key element in the evaluation of 1° HPT. It should be stressed that any PTH level should be measured with a simultaneous serum calcium determination. A normal or high normal PTH level with an elevated serum calcium is abnormal although the PTH level may not be absolutely elevated. Our mid-molecule measurement for PTH was very helpful, being elevated in 95% of patients. There is some controversy regarding which portion of the PTH molecule should be assayed to be most helpful in diagnosing 1° HPT. The short half-life of the N-terminal fragments may limit detectability in this disorder. If however, the level is elevated, a significant increase in hormone production is occurring. The experience of the laboratory performing the measurements is perhaps the most important factor as is true of any radioimmunoassay.

Radiologic evaluation of these patients should include at the minimum a chest x-ray and some method of visualizing the kidneys. An intravenous pyelogram is preferred if the patient does not have altered renal function or heavy proteinuria. The reason for this is, of course, to rule-out the most common malignancies — lung and renal — that cause hypercalcemia but are not detectable by physical examination. Hypernephroma can be very subtle and may mimic 1° HPT. Of interest is a recent Mayo Clinic paper showing that 1% of patients with 1° HPT also had a renal tumor present at the time of diagnosis.[7] Hand films do not appear to be a cost-effective means of diagnosis.

Treatment for the asymptomatic patient with 1° HPT is somewhat controversial.[8-9] The renal and bone damage done by this disease process is subtle, and the interstitial calcium deposition in the kidneys of these patients is clinically indolent and not easily detected by radiographic testing. Loss of bone mass may also be subtle as we know that bone mass loss must be 30% before it is detectable on plain x-rays. This loss of bone mass can be particularly detrimental in postmenopausal women, the group most affected by this disease.

Continued acceleration of post-menopausal bone loss would be expected to result in an increased risk of hip and vertebral compression fractures. Medical therapy for 1° HPT — including cimetidine, propranolol, and diphosphonates — has not been successful.[10] Surgical excision of the adenoma or of the hyperplastic glands continues to be the most successful therapy. We recommend that the majority of patients undergo surgical exploration. This

(Continued on page 168)

Perspectives on Leprosy

Dorothy Merritt* ***and*** **Douglas W. Voth, M.D.,†** ***Wichita***

Leprosy (Hansen's Disease) is seldom encountered by most physicians except in the library. Indeed, the incidence of leprosy in the United States is only .001% of the worldwide total.[1] Kansas has recorded only 16 cases since 1920, all of which have been imported, including three since 1981. Yet an increasing number of refugees from areas of the world where leprosy is endemic have been relocated in the Midwest, and the physicians in the region may be called upon for diagnosis and management.

The physician who treats a patient infected with *Mycobacterium leprae* needs to understand not only the natural course and current therapy of Hansen's Disease, but also must deal with the reactions of society and family members — often these consist of intense repugnance and ostracism.

This article will provide historical perspectives of the attitudes surrounding leprosy, review the discovery of the etiologic agent and the establishment of the United States leprosarium, and provide recent epidemiologic data of leprosy in the United States.

Ancient Origins

Leprosy is a chronic disease of the skin and nerves which has been described since ancient times. Early Judeo-Christian society associated leprosy with spiritual impurity, and horrible deformities and mutilations were commonplace until effective treatment became available only 30-40 years ago. The word still evokes a morbid fear.

The actual cradle of leprosy is unknown; historical treatises indicate that it originated in Africa, China, or India.[2, 3] It appears to have been unknown in Europe prior to the return of Alexander the Great's troops from the Indian Campaign.[4] Numerous Biblical references to leprosy apparently refer to a number of skin conditions with widely varied causes rather than the disease as it is known today.[5, 6]

Medieval Attitudes[7]

Biblical attitudes toward leprosy extended into Medieval times: the leper was still considered to have a moral contagion that required exclusion from the community. Sanctions against lepers were a joint function of church and community, and mandated physical separation from all other persons. When in a public place, the leper was required to call out "unclean, unclean" while sounding a warning bell or rattle. Lepers were buried alone or in leper graveyards, so in life or death they could experience companionship only with a spouse or with other lepers.

Medieval leper hospitals required adherence to strict regulations designed for the salvation of the soul rather than the healing of the body, but were nevertheless considered a luxury.

Norwegian Leprosy

Leprosy probably was brought to Norway by the Vikings in the eighth to tenth centuries from the British Isles. The first Norwegian leprosarium was founded in conjunction with a cathedral in the 12th century; but it was not until 1817 that a physician was included in the care of lepers.[8] True reforms in care began with the scientific endeavors of Daniel C. Danielssen and Carl Boeck, who published "Om Spedalskhed" (On Leprosy) in 1839,[9] the first meticulous work to describe the pathologic anatomy of leprosy.

Armauer Hansen was a physician for a small community of Norwegian cod-fishermen. In 1868, his duties were expanded to include the care of patients at the nearby leprosarium in Bergen with Danielssen as his chief. After several years of work with the yellowish granular masses in the lymph nodes of lepers (previously noted by Danielssen), he was able to demonstrate brown rod-shaped objects in large "lepra cells."[10] Nevertheless, it was some years before staining techniques became sophisticated enough to enable him to isolate the leprosy bacillus.

L. Wood Memorial Fund[12]

The world-wide scope of leprosy research and epidemiologic investigation was greatly enhanced by the initial efforts of three men: Drs. Leonard Wood, H. W. Wade, and V. Heiser. Wood, an ex-Chief of Staff of the Army and a physician, was subsequently appointed Governor-General of the Philippine Islands, where he visited a leprosarium.

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With the assistance of Dr. Wade, a professor of pathology and bacteriology at the University of the Philippines in Manila, and Dr. Heiser, who worked at the International Health Division of the Rockefeller Foundation, the L. Wood Memorial for the Eradication of Leprosy was incorporated in 1928 as a non-profit organization. Its purpose was to stimulate research and further epidemiologic studies as well as promote the training of leprologists. The Memorial sponsored an international conference that resulted in the collaboration of data from all over the world and the formation of the *International Journal of Leprosy*. Although World War II caused the temporary cessation of research based in the Philippines and the destruction of much data, the Wood Memorial continued worldwide aid and funding of leprosy research.

Leprosy in the United States

In 1893, the *New Orleans Daily Picayune* ran a media campaign calling attention to the fact that the number of cases of Hansen's Disease in the state was increasing. As a result, the Louisiana legislature alloted meager funding to establish a hospital at Tulane University with research facilities for leprosy. After community opposition thwarted efforts to obtain land, a deal was negotiated in 1894 to lease property 85 miles up the Mississippi under the pretense that it would be used as an ostrich farm. Dr. Dyer, seven patients, an entourage of newspaper reporters, and 80 hospital beds arrived at the run-down farmstead via coal barge in the middle of the night in November 1894. The Louisiana Leper Home, as it was known then, became the National Leprosarium when it was purchased by the United States Public Health Service in 1921. Prior to that purchase, the patients of the leper home had survived for more than 25 of 27 years without a resident physician and had been cared for by the Daughters of Charity of St. Vincent de Paul, a religious order of charity nuns.

Probably the most significant early advancement that came out of the Carville facility was Dr. G. Faget's experiments with glucosulfone sodium (Promin), a sulfa drug that he obtained from the Mayo Clinic after reading about some experiments with its use to treat *Mycobacterium tuberculosis*.[15] After several years of trials with this drug, it was clear that sulfones were capable of arresting the disease in the majority of patients, and it replaced the time-honored chaulmoogra oil treatment, as well as some of the other previously used remedies which included antimony, mercury, juniper oil, volcanic mudbaths, viper potions, and even well water. One sage observer noted that well water seemed to cause the least number of side effects. It is interesting to



Figure 1. Reported cases of leprosy by year in the United States, 1955-1981. (MMWR-1981 Annual Summary, US Dept. HHS, Public Health Service, October 1982)



Figure 2. Leprosy cases reported to Hansen's Disease Center, 1967-1982. (Courtesy of Ms. Barbara Maxwell, Epidemiology section of the HDC)

speculate that some of these medicaments may have had some effect on host defense, if not the organism.

Today leprosy is clearly a treatable disease and isolation in a leprosarium is not necessary to prevent spread of infection. Surgical procedures have been developed that allow repair of the many deformities which can result from previously untreated leprosy; special footware and physical therapy are available to prevent potential damage from neurosensory deficits. In light of these developments, there is no need to fear or loathe such patients; many people now advocate the use of the term Hansen's Disease instead of leprosy to avoid the legacy of negative connotations.

Current U. S. Epidemiology

The incidence of leprosy in the native born population in the U. S. has remained relatively stable during the past 15 years, but there has been a dramatic increase recently in the foreign born cases as reported to the CDC[16] *(Figure 1)* and also the Hansen's Disease Center (HDC) *(Figure 2)*. More recent and comprehensive data from the HDC surveillance system include reports and admissions to Carville from among U. S. residents and a few from foreign countries who come solely for treatment of their disease and associated deformities.

The total number of new leprosy cases reported by the HDC increased from 186/year in 1977 to 349/year in 1982 *(Table I)*. The total of 1666 cases reported during the six years 1977-1982 surpassed the 1432 cases reported during the previous decade.[17]

The vast majority of the 1666 cases reported by the HDC were foreign born; 1488 cases (89.3%) occurred in this group; only 178 cases (10.7%) were reported in the U. S. native born population. The number of imported cases has increased from 153/year in 1977 to 320/year in 1982, while the number of cases among U. S. native born population has remained relatively stable with 25-33 cases per year during the same period. Of the 1666 HDC-reported cases, 1089 (65.3%) were classified as the multibacillary type of the disease (lepromatous and dimorphous), 498 (30.0%) were classified as paucibacillary (tuberculoid and indeterminate), and 79 (4.7%) were unclassified.

As in the past, the majority of cases imported to the U. S. from 1977 to 1982 were patients who were born in countries with high endemic rates of leprosy *(Table II)*. The number of cases imported from Mexico and the Philippines has increased slightly, but the increase contributed by Vietnam has been significant. In 1982, 100 of the 320 imported cases (31.0%) were among those of IndoChinese origin.

The majority of the 178 native born leprosy patients during 1977-1982 were from three states: Texas with 85, and Louisiana and Hawaii with 24 each *(Table III)*. Of the 349 cases reported in 1982, 154 patients were in the 21-40 year age range, although there is a fairly even spread from the second through the sixth decades.

Distribution of the 1982 cases of Hansen's Disease by state is shown in *Table IV:* California, Hawaii, New York, and Texas contributed 253 of the 349; only one case was reported in Kansas.

Enna reported the ratio of imported to native born cases to have increased to 75:25 for 1967-1976 from approximately 50:55 during the previous 20 years. The largest increase appears to be among the Vietnamese and the Filipinos. In 1982, Vietnam, Laos, Cambodia, China, and the Philippines contributed

TABLE I
CASES OF LEPROSY REPORTED TO HANSEN'S DISEASE CENTER 1977-1982

Year	*Native Born*	*Foreign Born*	*Total No of Cases*
1977	33	153	186
1978	29	169	198
1979	25	196	221
1980	29	287	316
1981	33	363	396
1982	29	320	349
1977-82	178	1488	1666

Courtesy of Ms. Barbara Maxwell, Hansen's Disease Center (HDC)

TABLE II
BIRTHPLACE OF FOREIGN-BORN PATIENTS WITH LEPROSY REPORTED TO HANSEN'S DISEASE CENTER 1977-82

Year	*Mexico*	*Phil. Is.*	*Viet Nam*	*Other*	*Unknown*	*Total*
1977	40	39	15	46	13	153
1978	44	31	21	60	13	169
1979	52	44	19	62	19	196
1980	56	65	52	120	0	298
1981	74	55	58	96	80	363
1982	51	75	57	121	16	320
Total	317	309	222	499	141	1488

Courtesy of Ms. Barbara Maxwell, Hansen's Disease Center (HDC)

TABLE III
BIRTHPLACE OF NATIVE-BORN PATIENTS WITH LEPROSY REPORTED TO HANSEN'S DISEASE CENTER 1977-82

Year	*Texas*	*La.*	*Hawaii*	*Other*	*Total*
1977	12	7	7	7	33
1978	16	2	4	7	29
1979	14	4	2	5	25
1980	13	3	3	10	29
1981	18	2	5	8	33
1982	12	6	3	8	29
Total	85	24	24	45	178

Courtesy of Ms. Barbara Maxwell, Hansen's Disease Center (HDC)

TABLE IV
STATE DISTRIBUTION OF LEPROSY: 1982

California	126
Hawaii	58
New York	36
Texas	33
Florida	16
Illinois	11
Washington	9
Louisiana	8
Other	52
Total	349

Courtesy of Ms. Barbara Maxwell, Hansen's Disease Center (HDC)

more than 54% of the total U. S. cases, a 34% increase from these Asiatic countries as reported by Enna for 1967-1976. The major reasons for the recent increase according to a recent report[18] are increases in the number of refugees from leprosy-endemic areas of the world and the development of dapsone resistance in these same areas; the importance of the latter remains to be proved.

Some immigrants with leprosy may have been inadequately treated or may have developed dapsone resistance; two-drug treatment using dapsone and rifampin is used in the U. S. to prevent this, but in developing nations — where the cost of rifampin is approximately 1000 times that of dapsone — two-drug treatment is not common.

The majority of leprosy cases reported in the U. S. are of the multi-bacillary type; there has been no significant change in the type reported in the U. S. since Enna's 1978 report. Why is this form of the disease so prevalent in the U. S. when the pauci-bacillary forms are much more common worldwide? It may be that this form is recognized by physicians in the U. S. more frequently because of its more obvious manifestations, and the greater likelihood of such an individual to seek medical treatment.

Physicians in the U. S. may be less likely to diagnose or consider leprosy because of their lack of experience. Under-reporting of leprosy may result from underdiagnosis as well as consideration of the severe social stigma associated with the occurrence of the disease. Despite widespread belief that leprosy is easily transmitted, it is relatively non-contagious even without treatment and completely non-contagious within a short time after institution of appropriate chemotherapy.

Conclusion

The increase in leprosy in the U. S. is due entirely to an increase in imported cases, primarily in Asian immigrants. Multi-bacillary disease is more prevalent in the cases reported in the U.S., unlike the majority of worldwide cases. Most reported cases occur in the 10-60 year age population.

The social stigma attached to this disease is undeserved and is born of ignorance and fear; it is a carryover from old Biblical laws which probably referred to a large group of diseases that included leprosy.

Immigrants undergo thorough physical examinations just before or at the time of entry into the U. S., but because of the long incubation period and potential dapsone resistance, investigation for changes associated with leprosy should be included in annual examinations of immigrants from endemic areas.

Leprosy is a reportable disease and at present, both the CDC and HDC should be notified. Free chemotherapy is available through most local public health centers, and hospitalization is available to anyone with suspected *Mycobacterium leprae* infection at the Hansen's Disease Center, Carville, Louisiana.

References are available on request from Dr. Voth, Department of Internal Medicine, UKSM-Wichita, 1010 No. Kansas, Wichita KS 67214.

Obstructive Sleep Apnea

SCOTT A. LERNER, M.D. *and* WILLIAM T. CECIL, RRT, CPFT, *Kansas City, Missouri*

THE SYNDROME of obstructive sleep apnea is not uncommon. The pathophysiology of this disorder is thought to involve collapse of the pharyngeal muscles during sleep, which produces obstruction of the upper airway. Associated with this obstruction is significant oxyhemoglobin desaturation and sleep fragmentation.

Several modalities of therapy have been described. These include weight loss, pharmacologic therapy such as progesterone or protriptyline, and tracheostomy. Tracheostomy represents the most definitive form of therapy, in that it is successful in producing a resolution of the obstructive sleep apnea syndrome and its associated disorders. Recently, a noninvasive modality of therapy (the use of continuous positive airway pressure) has been described. Described here are our experiences with 24 patients in whom we tested oro-nasal continuous positive airway pressure as a treatment modality for obstructive sleep apnea syndrome.

Methods

Retrospectively, 24 subjects, 20 males and four females whose ages ranged from 34 to 75 years (50.9 ± 11.15), were selected for this study on the basis of an obstructive + mixed apnea index of > 11[1] (the sum of mixed apneas + obstructive apneas divided by the total sleep time [TST] in hours). Height ranged from 152.4 to 193 cm (173.2 ± 9.7). Weight ranged from 79.6 to 159 kg (105.6 ± 22.1). No attempt was made to exclude any patients based on any criteria other than the mixed + obstructive apnea index. The presence of obstructive sleep apnea was documented in an overnight recording. Subsequently, these same subjects were scheduled for a second overnight recording while employing continuous positive airway pressure via a tight-fitting oro-nasal mask (Vital Signs, Inc., East Rutherford, New Jersey) at pressures ranging from 2.5-16.5 cm of H_2O. These polysomnographic studies consisted of a central and occipital electroencephalogram (EEG) lead (C4A1 or C3A2 and O1A2 or O2A1 respectively), 2 electro-occulogram (EOG) leads (ROCA1, LOCA2), and submental electromyogram (EMG). Flow was recorded at the nose and mouth using a pneumotachograph that was seated in the mask.

Respiratory effort was monitored using anteroposterior rib cage and abdominal movements by respiratory inductive plethysmography (Respitrace, Ambulatory Monitoring, Inc., White Plains, New York). Arterial oxygen saturation was monitored continuously by ear oximeter (Biox IIA, Ohmeda, Boulder, Colorado). Sleep staging was performed according to the criteria of Rechtscaffen and Kales.[1] Total sleep time and wake after sleep onset (WASO) were defined using the criteria of Carskadon.[2] WASO is a measure of the cumulative effect of the frequency and duration of arousals that occur during sleep and is calculated by adding all of the wake time after sleep onset and before the final wakening of the night, expressed as percentage of the total sleep time. Sleep efficiency was defined as the total sleep time divided by the total dark time (the time from lights out at the beginning of the test until the end of the night) × 100. Apnea and desaturation indices were calculated as a total number of events for that category divided by the total sleep time in hours. Desaturation was defined as a fall from the baseline oxygen saturation of at least 4%.[3] In addition, the minimum oxygen saturation for the night was determined in each subject. All values obtained from the control night and the CPAP night were compared by paired t-test analysis.

Results

The effect of CPAP on apnea indices are shown in *Figure 1*. The obstructive apnea index decreased from 65.63 ± 37.87 on the control night to 6.69 ± 17.49 on the CPAP trial night; $P < .0005$. The mixed apnea index decreased from 6.73 ± 12.81 on the control night to 0.83 ± 1.36 on the CPAP trial night; $P < .025$. The central apnea index increased from 2.75 ± 5.65 on the control night to 5.92 ± 15.14 on the CPAP trial night (no significant difference).

The effect of CPAP on oxygen saturation is shown in *Figure 2*. The oxygen desaturation index decreased from 75.71 ± 31.77 on the control night to

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KMS

Kansas Medical Society Newsletter

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HOUSE OF DELEGATES ACTIONS

Among the resolutions adopted by the House of Delegates this month were the following:

85-1 Educational Information on Hospital Staff Privileges: KMS HMSS will provide guidelines to aid medical staffs in the credentialing process.

85-2 DRGs, PRO and KFMC: KMS Hospital Medical Staff Section will monitor DRG related complications and KFMC related complaints.

85-8 Conflict Resolution between hospitals and medical staffs will be a joint effort by the proposed KMS/KHA mediation committee.

85-10 Quality Assurance for hospital sponsored programs is urged of hospital medical staffs.

85-12 Unified Membership: Creates a tri-level membership (county, state, AMA) beginning in 1986.

85-17 Medical School Class Size: KMS will study the supply of physicians in the state.

85-27 Medicare Reimbursement for Anesthesiology Services: KMS recognizes the inequities and supports the Kansas Society of Anesthesiologists.

85-29 KMS PPO: KMS will study the possibility of developing and implementing a PPO.

DETAILS IN JULY KANSAS MEDICINE

MEET YOUR PRESIDENTS



lair C. Conard
Dodge City
President



Franklin Bichlmeier
Kansas City
President Elect



Donald W. Hatton
Lawrence
1st Vice President



Terry L. Poling
Wichita
2nd Vice President

In This Issue...

- House of Delegates Actions
- Meet Your Presidents
- Legislative Summary
- Medical Records
- National Simple Speak Day
- Waiting: PR in Your Office
- Forums on Aging: KMS PR Project
- Medical Directory

LEGISLATIVE SUMMARY

The 1985 legislature adjourned Saturday, April 27, after on of the more productive sessions in recent memory. Among th more controversial issues addressed was that of medical malpractice.

The legislature passed and Governor Carlin signed, Substitu for Senate Bill 110, which was developed and supported by t Kansas Medical Society and the Kansas Hospital Association. Although it dealt with only two issues, punitive damages an the collateral source rule, the bill took on much signifi- cance. It is the first time any substantive tort reform ha passed the legislature, which is heavily influenced by the Kansas Trial Lawyers Association. This legislation sets th stage for more progress to be made in 1986.

Passage of this bill was essential in that it demonstrated that the legislature is serious about looking into the problem, and it also helps provide immediate benefit. In fact, as a result of the enactment of Substitute for SB 110 the Health Care Stabilization Fund surcharge that was origi nally planned to be 120%, has been revised down to 110%. There may be much larger savings in following years, as the collateral source rule begins to affect more claims. Malpractice insurance companies are also looking at holding down planned increases as a result of Substitute for SB 110

A ten-member legislative interim committee will begin a comprehensive study of malpractice this June. KMS will tak an active role and push for additional reforms. Please wat your mail for developments.

Other issues dealt with by the legislature this year included:

Certificate of Need: At the urging of KMS and the Kansas Hospital Association, the state's ten-year-old certificate of need law will expire this July 1. In conjunction with the sunset of certificate of need, a two-year moratorium on the construction of new hospita beds will take effect. The legislature passed the hospital bed moratorium as a temporary method to stop expansion of acute care beds while new, emerging payme systems shake out.

Nurse Anesthetists: The bill which would have clarifi and regulated the practice of nurse anesthesia got bogged down and did not pass the legislature. It is likely that the legislature will study this issue this summer.

Respiratory Therapy and Occupational Therapy: Bills which would have credentialed respiratory therapists and occupational therapists were held over and will probably be studied this summer.

Baby Doe Restrictions: A bill that would have prohibited physicians from withholding treatment from severely handicapped newborns did not pass this year. KMS opposed the bill on the grounds that state legislation was unneeded because of recent federal action in this area.

Abortion Reporting: A bill which would have required physicians to annually report abortions to the Department of Health and Environment did not pass. KMS opposed the bill.

PPOs: A bill which would have regulated the development and operation of PPOs got lost in the last minute shuffle during the closing days of the legislature. KMS supported the bill after several amendments were added, and it is expected that the measure will pass next year.

Newborn Screening: After July 1, 1985, the required newborn screening for phenylketonuria, galactosemia and hypothyroidism will be centralized and done by the Department of Health and Environment's laboratory. The bill passed despite objections from private laboratories and hospitals which currently provide such newborn screens.

Midwifery: Legislation to authorize the practice of lay midwifery in Kansas did not pass the legislature. KMS opposed the legislation.

Mandatory Use of Seatbelts: The legislature killed two bills which would have mandated the use of seatbelts for each front seat occupant of a passenger car.

In all, KMS actively followed about 75 pieces of legislation this session. Above are some of the more important bills that were considered this year, but if you have questions on other legislation, please contact the KMS office.

MEDICAL RECORDS

Who owns the medical record? The medical record is a regular business record of the physician, clinic or hospital. The law grants the patient access to the information, but not the record itself. Physicians should explain to their patients the difference between access and ownership. Many patients mistakenly believe that because they pay physicians for their services, the records belong to the patient. (Other aspects of the medical record issue will be presented in subsequent issues of the Newsletter.

GOBBLEDYGOOK

June 1 has been designated as the National Simple Speak Day to encourage politicians, educators, executives, bureaucrats, journalists, lawyers and computer programmers to observe this day by using ordinary, understandable language. Good luck!

WHO WILL LIVE?
WHO WILL DIE?

Biotechnology has spawned sophisticated life-support equipment that can prolong a patient's life indefinitely. A special KMS/SRS Ethics committee is attempting to grapple with the challenges posed by modern technology from the medical, ethical, legal and humanitarian points of view.

WAITING TIME

According to a recent article in Los Angeles Times, research shows that an acceptable waiting time for patients in the doctor's office is 15-20 minutes. Patients become irritated if they wait longer. Patients expect a brief wait and understand that delays are sometimes unavoidable; however, they also expect courtesy, consideration and respect for their time. The patient may be taking time off work without pay. There may be dependents left at home unattended. The patient may have other commitments. In an effort to ease the frustrations of waiting, it is recommended that the patients be acknowledged immediately upon arrival:

- Let the patient know if there will be any delay. If it will be lengthy, offer them a chance to come back later or reschedule;
- Give patients interesting reading material, including pamphlets about current medical problems;
- Don't put patients in an examining room until the physician is nearly ready for them;
- In those offices where the patients are made to wait habitually, it may be advisable to re-examine the daily schedule and leave some open slots for the unforeseen.

FORUMS ON AGING

The Kansas Medical Society opened new avenues of understanding with senior citizens about health care costs in a series of forums throughout the state. This year's effort was co-sponsored by Kansas Department on Aging and KMS Auxiliary at Emporia, Hays, Lawrence, Topeka and Wichita. Program presenters were Jay Lohmann, Kansas Director of Medicare; Sylvia Hougland, Secretary, KDOA; local representatives of hospital, pharmaceutical, nursing homes and home health industries; Sen. Jeanne Hoferer and Rep. Jessie M. Branson. The following physicians participated: Thomas P. Butcher, Norton L. Francis, Donald W. Hatton, William R. Lentz, Harry E. Watts.

MEDICAL DIRECTORY

A listing of physicians, hospitals, and laboratories has been published--but not by the AMA. Titled U.S. Medical Directory, Seventh Edition, the book is compiled and published by the U.S. Directory Service of Miami FL, which charges $35 to list a physician. The private directory is not to be confused with the AMA's comprehensive, four-volume publication titled American Medical Directory. The AMA directory lists all U.S. physicians at no charge. The 29th edition of the AMA directory is available for purchase. The 4-volume set costs $375. Only 3,000 copies of this edition have been printed.

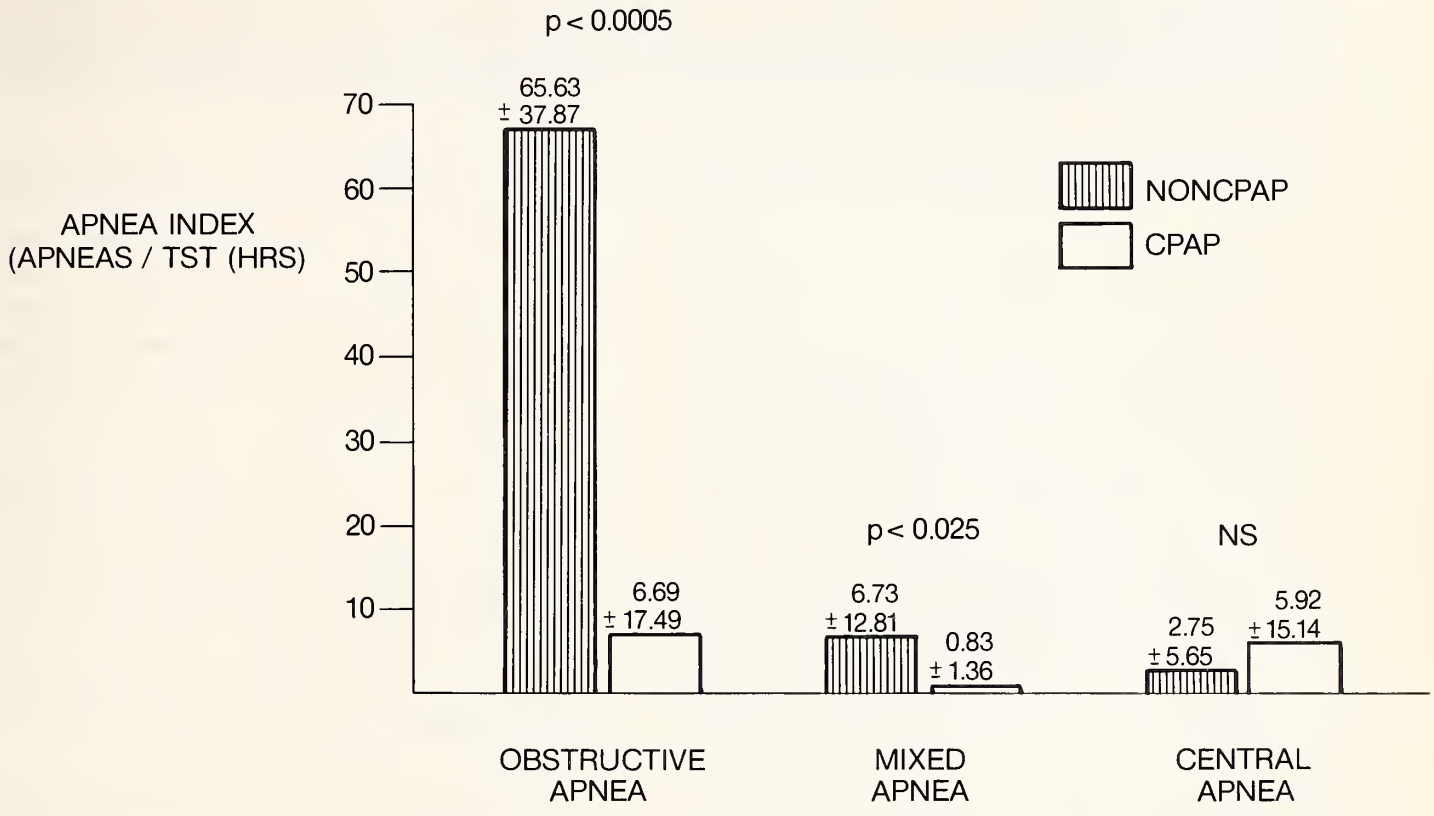


Figure 1. Apnea index by apnea type for the control night (non-CPAP) and the CPAP trial night (CPAP).

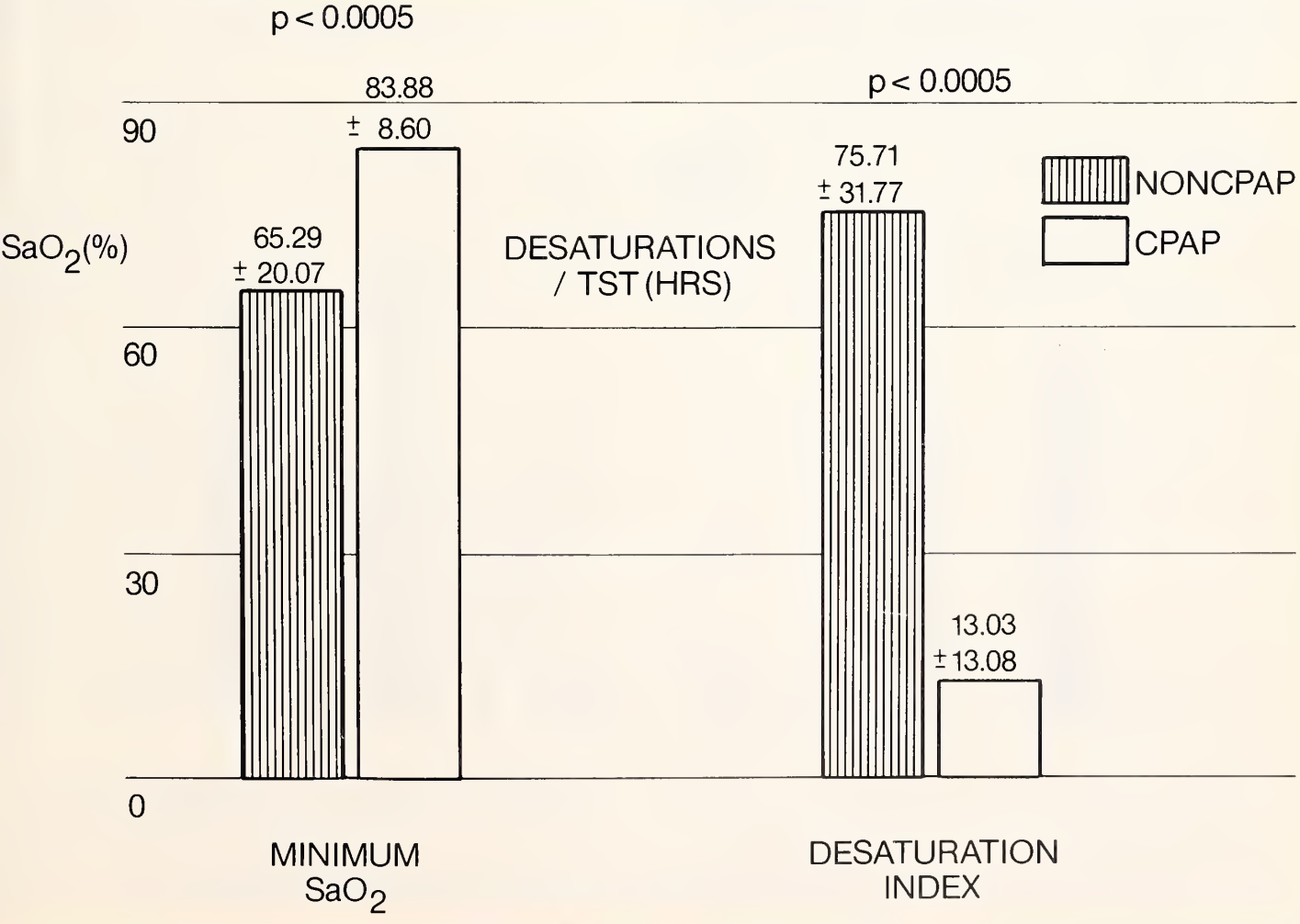


Figure 2. Minimum O_2 saturation (%SaO_2) for the night; desaturation index for the control (non-CPAP) night and the CPAP trial night (CPAP).

13.03 ± 13.08 on the CPAP trial night; P < .0005. The minimum O_2 saturation increased from 65.29 ± 20.07 on the control night to 83.88 ± 8.6 on the CPAP trial night; P < .0005. The effect of CPAP on sleep distribution is shown in *Figure 3*. Stage 1 sleep decreased from 50.7 ± 24.42% of the TST on the control night to 18.3 ± 11.14% of the TST on the CPAP trial night; P < .0005. Stage 2 sleep increased from 41.6 ± 20.7% of the TST to 51.4 ± 15.9% of the TST on the CPAP trial night; P < .05. Stage 3-4 sleep increased from 3.99 ± 7.3% of the TST on the control night to 10.4 ± 9.9% of the TST on the CPAP trial night; P < .01. REM sleep increased from 3.7 ± 4.1% of the TST on the control night to 19.8 ± 13.2% of the TST on the CPAP trial night; P < .0005. WASO decreased from 62.6 ± 34.4% of the TST on the control night to 28.7 ± 20.9% of the TST on the CPAP trial night; P < .0005. Sleep efficiency increased from 59.2 ± 11.5% on the control night to 75 ± 13.6% on the CPAP trial night; P < .0005.

Discussion

The results of this study demonstrate that the application of continuous positive airway pressure in the range of 2.5-12.5 cm of H_2O during sleep significantly reduces the frequency of apneas. The application of CPAP significantly reduced the frequency of desaturations and improved the minimum O_2 saturation for the night. In addition, the quality of sleep improved as shown by a significant decrease in the amount of the total sleep time spent in stage 1 sleep and a significant increase in the amount of total sleep time spent in stage 3-4 and REM sleep. Sleep efficiency improved significantly and WASO decreased significantly during CPAP indicating that the frequency and the duration of arousals decreased significantly.

A precise dose response curve for the range of CPAP pressures was not constructed. The level of CPAP was titrated in each patient to the level that was associated with the largest decrease in the number of apneas. Positive pressures greater than 12.5 centimeters of water were not instituted generally.

The data reported in this study compare very favorably to those of Weitzman *et al.*, who reported on ten patients with hypersomnolence and apnea syndromes following tracheostomy. In these patients, the mean apnea index decreased from 109 on the control night to 25 following tracheostomy.

(Continued on page 162)

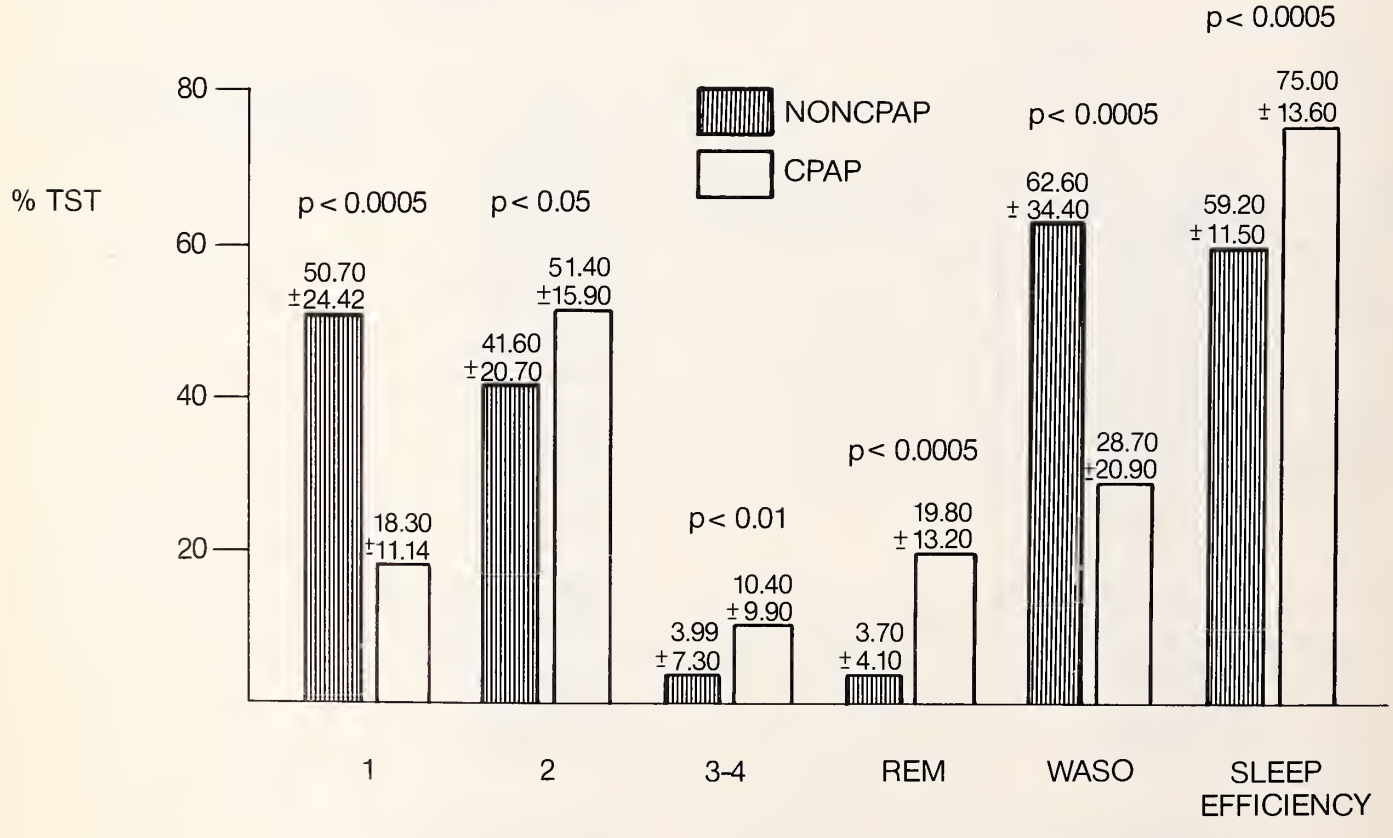


Figure 3. Sleep distribution for the control night (non-CPAP) and the CPAP trial night (CPAP).

CURRENT COMMENT

Snakebite: First Aid & Hospital Management

SCOTT S. TALPERS, M.D.,* *and* JAMES J. BERGIN, M.D.,† *Kansas City, Kansas*

The World Health Organization estimates that 500,000 venomous snakebites occur in the world each year, resulting in 30,000 to 40,000 deaths. The greatest mortality occurs in tropical Asia and Africa, where venomous snakes are numerous, and medical care is often inadequate.

In the United States 45,000 snakebites occur each year, with an estimated 8,000 of these bites being venomous in nature. Each year, fewer than 20 of these victims die. The highest mortality occurs in children, the elderly, untreated, undertreated, and the chronically ill.

There are five families of venomous snakes in the world:

- Elapidae: Cobras, kraits, mambas and coral snakes
- Viperidae: Old world vipers
- Crotalidae: Pit vipers (rattlesnakes, copperheads, water moccasins), bushmasters, and fer-de-lances
- Hydrophidae: Sea snakes
- Colubridae: Boomslangs and mangrove snakes

In the United States, only two of the five are found in nature; Elapidae and Crotalidae. There are four genera of venomous snakes representing these two families that inhabit our country: rattlesnakes, copperheads, water moccasins, and coral snakes.

Coral Snakes

The coral snake is the only member of the family Elapidae found in this country. It has red, yellow, and black bands the length of its body. The yellow bands always surround the red and black bands, in contrast to several non-venomous snakes with similar coloring whose red and black bands border one another. Coral snakes are reclusive and seldom bite unless provoked. Two species of coral snakes inhabit the United States, the Eastern coral snake and the Arizona coral snake.

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Pit Vipers

Pit vipers comprise 17 of the 19 species of venomous snakes found in the United States, and are members of the Crotalidae family. They are composed of 15 species of rattlesnakes, with the water moccasin and copperhead. This class of snakes derives its name from a pit or deep hole which functions as a heat sensor, and is located between and below the eye and nostril. These snakes have triangular heads and cat-like vertically-elliptical pupils. Located in the mouth are a pair of hollow fangs through which the venom is injected.

Rattlesnakes. There are 15 species of rattlesnakes found in the United States. They are named for a set of rattles located at the end of the tail, which are used to warn potential predators. Many strikes occur without advance warning.

Four species of rattlesnakes inhabit the Kansas-Missouri region: the Timber rattlesnake, Western rattlesnake (Kansas Subspecies — Prairie rattlesnake), Pigmy rattlesnake, and the Massasauga.

Copperheads. Copperheads are found along wooded hillsides, in rocky outcrops, and near streams and ponds. Fatalities and permanent tissue destruction are infrequent results of the copperhead bite. Thus, many authorities are reluctant to treat previously healthy adults with antivenin, because the risk of anaphylaxis exceeds the danger of the bite.

Water Moccasins. Water moccasins live in swamps, and near lakes, rivers, streams, or ditches. They are generally aggressive, and like the rattlesnakes, their bite can inflict long-term tissue damage and even death. They are also known as "cottonmouths," due to the whitish coloration of their oral mucosa.

General Facts About Snakes

Snake venom is composed of various concentrations of the following enzymes: hyaluronidase, proteases, phosphatidases, phosphoesterases, cholinesterases, and numerous toxic proteins. Systemic absorption of venom occurs through the lymphatics, unless the strike is directly into a blood vessel.

Numerous factors affect the actual amount of venom delivered in a given snakebite. These include

the size of the snake, the time of the year the bite occurs, the aggressiveness of the snake, and the length of time since its last bite. There are tremendous differences in the toxicity of venom between different species of snakes. In an estimated 20 percent of bites, no significant amount of venom is discharged. Greater than 90 percent of bites occur on the extremities, and 90 percent occur between March and October, since snakes are cold-blooded and hibernate.

Signs & Symptoms of Envenomation

Coral Snake. The coral snake has numerous minute fangs, and chews during its bite to work its venom into the wound. The actual bite can be difficult to find, consisting only of tiny puncture sites. Symptomatic evidence of envenomation is often delayed for several hours, with the first symptom reportedly being euphoria. Drowsiness, ptosis, strabismus, tremors, excessive salivation, weakness, confusion, and vomiting quickly follow. If the bite is left untreated, death usually occurs within 8-24 hours from progressive paralysis and cardiopulmonary arrest. The venom is primarily neurotoxic in nature, producing progressive flaccid paralysis believed to be due to a curare-like effect at the neuromuscular junction, and probable damage to numerous CNS centers of function.

Pit Vipers. The bite of the pit viper produces one or two distinct puncture wounds. The most diagnostic sign of significant envenomation is the appearance of local swelling within minutes of the bite. Burning pain usually accompanies the swelling, but may be absent. The toxin rapidly alters blood vessel permeability leading to loss of plasma and blood into the surrounding tissue which produces edema and ecchymosis. Hemolysis, thrombocytopenia, and hemorrhage from multiple sites frequently occur. As the toxin spreads proximally by way of the lymphatics, progressive swelling occurs, and regional lymph nodes become tender and enlarged.

Systemic symptoms of envenomation include weakness, lightheadedness, parasthesias, diaphoresis, visual disturbances, nausea and vomiting, and syncope. In severe untreated envenomation, pulmonary edema occurs due to damage to the pulmonary vasculature and loss of plasma from increased vascular permeability. Acute renal failure may result secondarily to circulatory collapse or massive hemolysis. Death occurs in 6-48 hours in severe or untreated cases.

First Aid

1. Retreat out of the snake's striking range.
2. Encourage the victim to remain calm and avoid any unnecessary movements as this will slow the rate of absorption of the venom.
3. Immobolize the bitten extremity below the level of the heart to further slow absorption.
4. Place a lightly-constricting tourniquet five to ten centimeters proximal to the bite, and move it more proximally as the swelling progresses. The tourniquet should be loose enough to barely slip one finger underneath it. Studies have shown that up to 50 per cent of the amount of venom which normally would be systemically absorbed may be localized to the area of envenomation if a tourniquet is applied within 30 minutes after the bite. This procedure is of little benefit after a coral snake bite.
5. Make a one centimeter-long incision just through the skin parallel to the long axis of the limb and through each puncture site. Use oral or mechanical suction for one hour, or until antivenin is given. When begun promptly, this method can remove up to 50 per cent of the injected venom from the wound site. This procedure is effective if done within one hour of the bite, and should be performed if there will be greater than a 15-minute delay before transfer to a health care facility. Incision and suction is of little benefit in coral snake bites.
6. Transport the victim to the hospital, minimizing activity if possible, by using a stretcher or carrying the patient. If alone, the victim should walk slowly and rest periodically, performing the above measures first if it is necessary to walk for hours before reaching help. If available, the dead snake

TABLE I
DETERMINATION OF ANTIVENIN DOSAGE

Grade	*Signs and Symptoms*	*Amount of Antivenin*
Grade 0 (none)	No envenomation — no local or systemic reactions	None
Grade 1 (minimal)	Local swelling — no systemic symptoms	2-5 vials
Grade 2 (moderate)	Swelling beyond the bite — mild systemic symptoms and/or hematologic abnormalities	5-10 vials
Grade 3 (severe)	Marked local and systemic effects with hemolysis and/or coagulation abnormalities	10-15 vials
Grade 4 (very severe)	Same as Grade 3, but more sudden onset and more rapid progression	> 15 vials

should be brought with the victim to aid in identification.

Hospital Management

Initial Assessment. The management of the hospitalized snakebite victim begins with a rapid and thorough evaluation of the patient's general condition. Particular attention should be directed toward the signs and symptoms of envenomation and the potential venomous nature of the snake. Once envenomation has been established, the physician must decide on the amount of antivenin to be administered.

Skin testing using 0.1-0.2 cc of 1:10 saline solution of horse serum intradermally is performed to test for sensitivity. The test is positive if a characteristic wheal and flare appear within 15-30 minutes of injection.

While awaiting the results of the skin test, the following baseline laboratory results should be obtained: CBC, PT/PTT, electrolytes, BUN/creatinine, ABG, UA, and type and screen for red cell transfusion.

Intravenous access should be established, and the circumference of the bitten extremity should be carefully monitored to evaluate the progression of the swelling.

Antivenin

Patients suffering from envenomation from pit vipers are given Crotalidae polyvalent antivenin, produced by immunization of horses with four different venoms from this family. Venoms from all rattlesnakes, copperheads, and water moccasins share the same antigens.

The amount of antivenin given is determined by the grading system for pit viper envenomation *(Table I)*.

In situations where the skin test is positive, the physician must judge whether the potential benefits of antivenin are worth the risk of anaphylaxis. Grade 2 through grade 4 bites are serious situations where antivenin is required to prevent permanent disability and even death. Envenomation in children, the elderly, and in the chronically ill may be particularly life-threatening.

Antivenin is most effective if given within two hours, but may be of benefit even 12-24 hours after the bite. If given early, it neutralizes the venom at the puncture site, before it is absorbed. Once the venom has bound to its target organ however, antivenin is of little value.

Three to five vials of antivenin should be diluted in intravenous (IV) fluid, and given slowly during a 15 minute interval while monitoring for allergic reaction. If no reaction occurs, the designated amount is given during the next hour. Antivenin is given until the signs and symptoms of progressive envenomation have ceased, and the patient begins to regain a sense of well-being. Antivenin can also be given intramuscularly (IM) or subcutaneously (SQ), but is much less effective. Antivenin should never be injected directly into the wound. Many authorities recommend the use of up to 50 percent more antivenin in children than adults due to the child's increased susceptibility to the toxic effects of the venom.

In grade 2 through grade 4 envenomation in which an allergic reaction to antivenin occurs, the antivenin should be temporarily discontinued and epinephrine 1:1000 0.3 to 0.5 cc SQ, Benadryl 50 mg IV or IM, and Solu-Medrol 125 mg IV given. Once the reaction subsides, antivenin should be cautiously administered and subsequent reactions treated with further epinephrine and Benadryl.

When coral snake envenomation is suspected, five vials of Mucrurus fulvis antivenin are given, which will neutralize the maximum volume of venom that can be injected. The antivenin should be given as soon as possible. Mucrurus fulvis antivenin is utilized for Eastern coral snake envenomation. However, this antivenin is not effective for the bite of the Arizona coral snake, whose venom is less toxic. Antivenin is neither required nor available for Arizona coral snake bite.

Supportive Care. The cardiovascular status must be maintained by giving intravenous fluids, plasma expanders, and red cells as required. In unstable patients with significant hypotension, pulmonary edema or acute renal failure, CVP or Swan-Ganz monitoring may be of benefit. Vasopressor medication may be a useful adjunct to the primary treatment of intravenous fluids in these situations.

Disorders of coagulation should be treated with platelets, fresh frozen plasma, or cryoprecipitate.

Respiratory support with oxygen and mechanical ventilation may be necessary. This is particularly true after a coral snake bite, where loss of respiratory function may be prolonged.

Gram negative and anaerobic bacteria commonly inhabit the mouths of snakes. Broad spectrum antibiotics should be given, pending wound culture and sensitivity results.

Tetanus toxoid 0.5 cc IM should be given to patients not immunized within five years. Tetanus toxoid and 250 units of tetanus immune globulin are necessary for those with no previous immunization history.

Dialysis may be required in cases of acute renal failure. Close monitoring of electrolytes is crucial.

(Continued on page 167)

PRESIDENT'S MESSAGE



Who would have thought, a year ago, that the Kansas Senate would actually pass a bill to limit awards for pain and suffering, punitive damages, and eliminate the collateral source rules? All of this has occurred only because a great many people have been willing to sacrifice time and effort to call their legislators, discuss the medical liability problems with their patients, and go to Topeka to testify.

Dr. Cal Bigler, immediate past president of the Kansas Medical Society, has driven more than 30,000 miles on KMS business this past year, spending virtually every Tuesday in Topeka since the legislature convened in January. Equally involved has been Dr. Jim Gleason, who is head of the Professional Liability project and who sometimes finds it difficult to decide if he is a lobbyist or an obstetrician. There are many others who have worked through committees to help solve this problem.

But the work is not over. As of this writing, the Senate bill has not been accepted by the House of Representatives nor has the Governor signed the bill. The rest of the Medical Society's bill will be studied this summer and will need extensive lobbying by all of us. I hope physicians will realize how important this bill is to us and will respond when asked. One benefit of a crisis is that it solidifies our organization and motivates people to be involved. We must become active participants in the political process on a daily ongoing basis. We cannot afford to wait until crises develop.

Mark Twain once concluded a letter to his mother by stating, "I am sorry this letter is so long. If I had had more time, it would have been shorter."

C. E. Leonard, M.D.

President

EDITORIAL COMMENT

A Question of Atavism

Some months ago we came across a study of the skulls of woodpeckers that found their internal structure to be admirably prepared to withstand the mind-boggling habits of these birds without their winding up in a home for punch-drunk woodpeckers. The medical lesson of importance is that the human skull is not so equipped.

We turn only slightly now to the action of the AMA House of Delegates which called for a ban on boxing. Since it is the nature of such things that objectors will be more visible and vocal than supporters, it is not surprising that the considerable response reported by the media has been predominantly antagonistic to the AMA position. Nor is it surprising that most of the complainants have had more or less financial interest at stake. Not a few physicians, however, with little or no financial involvement, have been among them, and their sincerity, reflecting personal interest in individual fighters, is not in question. The complaints have been too numerous and broad to be treated here in any depth, but one of the prominently cited benefits of the activity is its character building potential.



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Our own experience is admittedly limited. At one point in college, we were confronted with the need for a semester of credit in Physical Education and elected, for some reason that still escapes us, to sign up for boxing. We proceeded with the lackluster attention we reserve for exercise. The final examination was a three-round bout, three minutes per round. Based on weight, we were pitted against a fellow almost eight inches shorter but with an arm-body ratio (and other traits) suggesting an orangutan. It was all too evident after the first two rounds that the score was 2-0 against us. As the third round started, our primary concern was whether we could even hold up those 16-ounce gloves for three more minutes. While we were considering the matter, our opponent landed a couple of good wallops to our nose. At this point, we got mad, abandoned the teachings, and laid to in a manner that may not have been textbook but won the third round for us. So much for character building. With a courtesy "C" in the course, we hung up our gloves and retired from the ring to rebuild our character (and nose) in other pursuits.

This limited background aside, what is disturbing to us is the attitude expressed by more than one physician-proponent that organized medicine (the AMA in this case) has no right to get involved. The AMA obviously signed for a tough match but why in the name of Apollo, Hygeia, and all the other folks shouldn't a medical organization make an effort to remove something that, however desirable in theory, becomes in practice an undeniable effort to inflict damage on the opponent? Is it an effort to bring the man out of the jungle or make him better able to survive there? Do these physicians support their other patients in activities which, despite attempts to neutralize risks, remain demonstrably harmful?

But the broader objection to such an attitude is that it denies the medical profession one of its important obligations: the effort to influence the public away from such pursuits. The voices are akin to those that have always been raised against movements that may restrict (for health consideration) individual or public activities that many enjoy. Actions that may curb established customs, desires, or financial considerations in favor of some future benefit have always met with similar outrage (as any public health activist knows). As Typhoid Mary learned to her regret, the concept of personal choice carries some superficial justification that no organized anything — government, medicine, or whatever — should interfere with that choice if it does not violate the more basic concept that the attitude is valid only if the proponents can demonstrate an absence of harmful effect on others.

Organized medicine need not apologize for attempting to intervene whenever there are medical effects of sufficient significance, frequency, or severity — including other sports that boxing enthusiasts are wont to cite as examples of other potentially dangerous activities. John Donne's advice that no man is an island is truer today than in the 15th century — and in ways he could hardly have imagined. — *D.E.G.*

SPECIAL FEATURE

In the Public Interest . . .

Eleanor Bell*

GARY CATLIN isn't a doctor and John Kohler isn't a lawyer. So how is it that they provide medical and legal services for the community of White City? For that matter, where is White City?

White City is a tiny community — about 500 residents — located northwest of Council Grove in Morris County. As in many other small rural Kansas towns, medical and legal services were unavailable locally. And that's where Catlin and Kohler came in.

Gary Catlin is President of the First National Bank of White City; John Kohler is a businessman and former mayor. They noted the inconvenience experienced by residents who had to travel to other communities for medical and legal services, and set out to find a better way.

"We talked with professionals from nearby communities about possible arrangements," said Catlin, "but soon discovered that none would agree to come here because of the lack of adequate facilities." Undaunted, the two men personally invested in a new building, which was completed last year.

Once adequate facilities were available, they were able to negotiate the services they needed. Charles T. Allred, M.D., and Michael Powers — the County Attorney of Morris County who also has a private practice — each agreed to spend one-half day per week in the new offices provided. Catlin and Kohler have since leased the remainder of the building to a trucking firm for its offices, but they continue to provide office space to Allred and Powers. The Morris County Community Hospital in Council Grove cooperated with the project by providing office furniture and equipment.

Charles T. Allred, M.D., graduated from the University of Kansas School of Medicine in 1978. He served a residency at Wesley Medical Center in Wichita prior to establishing a family practice in Council Grove in July 1982. Each Monday afternoon he drives the 25 miles from Council Grove to White City.

"It was slow at first," notes Allred. "People were accustomed to driving to Council Grove, Herington, or Junction City for medical services, and many had established a relationship with another physician. That's an important factor."

However, during the past year his White City practice has gradually increased, and he now sees an average of 15 patients each week — about the maximum patient load for one afternoon.

"Many younger people are accustomed to driving to other towns to work and shop, and they may not miss local medical services. But the older people really appreciate having a doctor available in their hometown."

Michael Powers is the County Attorney. In a rural community such as Morris County, neither volume nor salary justify a full time attorney, and Powers maintains a private practice in addition to his public duties. He comes from Council Grove to White City each Wednesday afternoon.

"The Court has cooperated with this project by keeping my schedule clear on Wednesday afternoons except in emergency situations," says Powers. "We've been involved in this program for more than a year, and it's worked out well."

"About 70% of the people I see (in White City) are walk-ins. There are days when I sit in the office all afternoon and never see a single person; other times people may be in and out continuously. An average day is probably two people."

The arrangement often generates *pro bono* ("for the public good") work for which Powers receives no fee. "The public tends to see me as County Attorney, and they look on that position as akin to legal aid. Often a person will drop in with a simple question that doesn't justify a charge."

Both men think the project is worthwhile. Powers notes that while the tangible rewards are small, the goodwill generated has a long-term value. In addition, he has the satisfaction of providing a service to the community. Allred has expanded his practice by bringing his services to people who need them. Both plan to continue the arrangement.

"I may look at the possibility of reducing the

* Editorial Staff Writer

hours a bit,'' says Powers, ''but that relates primarily to my work load otherwise — not to any problems with the White City arrangement.''

And that's just what Gary Catlin and John Kohler hoped for. Their future plans call for addition of a dentist and an optometrist to their part-time professional cadre.

So it is that two business leaders are providing medical and legal services to their home community. Perhaps the success of the innovative White City project will establish it as a model for the delivery of professional services to other rural communities.

VOX DOX

Vox Dox Editor:

''Male nurses alive, well in obstetrics.''[1] This article reported that, in the courtroom, hospitals justify the exclusion of male staff nurses from labor and delivery duty based on those facilities' concern for the intrapartum patient's privacy. A professor of law and medicine[2] and a nurse-attorney[3] have independently challenged that argument. Such challenges are validated by actual parturients' common acceptance of and satisfaction with care received from male nurses in four different settings.

Intrapartum patients have nearly always responded favorably to a male nurse at Fort Riley and to another at Wamego.[1] A Detroit male nurse has worked in labor and delivery for more than eight years and has had only one patient who objected to his gender.[4] A New York male nurse received the first Outstanding Nursing Practice Award in obstetrics/gynecology at the University of Rochester Medical Center's Strong Memorial Hospital, a tertiary referral facility. He was selected for that honor partly because, as a hospital periodical noted, ''Many of his patients have written to the hospital commending his care, and when he appeared on a local TV show, the station received many telephone calls from his former patients telling of his competence and support during their labor and delivery experience.''[5]

Yet many Kansas hospitals have an unwritten policy that requires all labor and delivery nurses to be female.[6] A few physicians have gone on record in support of that unwritten policy, according to two federal court cases.[7, 8] However, those physicians were not able to cite parturients in their own practice settings who were dissatisfied with care they had received from male staff nurses. Those physicians practiced in settings in which intrapartum patients are not allowed to receive care from male nurses.

When a Kansas hospital's medical staff discusses its policy on this matter, the author suggests that it is critical to notice that the above four varied references to male labor and delivery staff nurses in Kansas, Michigan, and New York *did* involve parturients who received care from male nurses and who generally reacted quite favorably.

Perhaps more Kansas medical staffs should consider allowing competent and qualified male nurses to help obstetrics meet the future goals, and those goals' personnel prerequisites, as advocated by Pritchard and MacDonald, toward nonprejudicial minimization of maternal, fetal, and neonatal mortality and morbidity through family-centered care.[9]

The Detroit male nurse mentioned above is now the head nurse of Sinai Hospital's labor and delivery unit. How would Kansas medical staff physicians respond if that particular nurse were hired for a corresponding labor and delivery position in their hospital? What would be the response from those who deliver babies?

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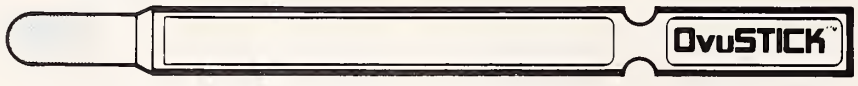
This article was written by Michael D. Brown in his private capacity. No official support or endorsement by the Indian Health Service of the U. S. Public Health Service is intended or should be inferred.

The writer wishes to acknowledge the review of these comments by Anne Wigglesworth, M.D., FACOG, Kaw Valley Women's Health Center, Wamego, Kansas; and John Calkins, M.D., FACOG, Dept. of OB/GYN, UKSM-KC.

References

1. Mullin D: Male nurses alive, well in obstetrics. *Topeka Capital-Journal* p 7, January 1, 1985.
2. Annas GJ: Male nurses in the delivery room. *Hastings Cent Rep* 11(Dec):20-21, 1981.
3. Greenlaw J: Delivery rooms: For women only? *Law, Medicine & Health Care* 9(Dec):28-29, 40, 1981.
4. ———: Man in labor. *Nursing 84* 14(Jul):8H, 1984.
5. University of Rochester Medical Center: Seven outstanding nurses named. *Vital Signs* 4(May 23):1, 1983.
6. Appleson G: Maternity wards may bar male nurses. *Am Bar Assoc J* 68:664, 1982.
7. Backus v. Baptist Medical Center, 510 F. Supp. 1191 (E.D. Ark. 1981).
8. EEOC v. Mercy Health Center, 29 FEP Cases 159 (W.D. Okla. 1982).
9. Pritchard JA, MacDonald PC: *Williams Obstetrics* 16th ed. New York, Appleton-Century-Crofts, pp 8-9, 1980.

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Obstructive Sleep Apnea

(Continued from page 154)

Guilleminault,[4] in a series of five patients with hypersomnolence-apnea syndrome, tested before and after tracheostomy, reported that the mean apnea index decreased from 65 to 13.

The high percentage of stage 1 sleep, the low percentage of stage 3 and 4 sleep, the low sleep efficiency, and the large WASO on the control night indicate that the patients reported in this study had severe sleep fragmentation. Of the 24 patients studied, 13 had no stage 3 or 4 sleep on the control night and three had less than one minute of stage 3-4 sleep. During the use of CPAP on these patients, 20 of 24 subjects had stage 3 and 4 sleep and, of these 20, only two had less than one minute of stage 3-4 sleep. The sleep fragmentation seen on the control night is similar to that reported previously in subjects with obstructive sleep apnea and is different from previously reported values for normal subjects.[5] Sleep distribution returned to near normal values during the use of CPAP. Improvement in sleep architecture which was seen in this study during the use of CPAP was reported also by Weitzman[6] in patients with hypersomnia-apnea syndrome following tracheostomy. Sullivan[5] and Mahadevia[7] reported similar improvement in sleep architecture in patients with hypersomnia-apnea syndromes during the use of expiratory positive airway pressure and nasal CPAP. The duration of REM sleep increased significantly during the use of CPAP in the patients presented in this study.

Sleep efficiency reported in this study improved during the use of CPAP. These data compare favorably to data reported by Weitzman, who found a 62% sleep efficiency on the control night and a 74% sleep efficiency after tracheostomy.

Conclusions

In summary, data reported in this study suggest that the use of continuous positive airway pressure delivered by an oro-nasal mask is an effective treatment for obstructive sleep apnea syndrome. The decrease in the apnea index, the total number of apneas and the oxyhemoglobin desaturation, as well as the improvement in sleep architecture, compares favorably with data reported following tracheostomy in patients with obstructive sleep apnea. The beneficial effects seen following acute studies during the

use of oro-nasal CPAP suggest that further studies should be instituted to evaluate long-term usage of continuous positive airway pressure as a treatment modality for patients with obstructive sleep apnea syndrome.

References

1. Rechtschaffen A, Kales A, eds: *A Manual of Standardized Terminology: Techniques and Scoring System for Sleep Stages of Human Subjects*. Los Angeles, Brain Information Service/ Brain Research Institute, University of California, 1968.
2. Carskadon MA: *A Manual for Polysomnography Technicians*. Stanford, Stanford University, 1980.
3. Block AJ *et al.:* Sleep apnea, hypopnea and oxygen desaturation in normal subjects — a strong male predominance. *N Engl J Med* 300:513-517, 1979.
4. Guilleminault C, Cummiskez J: Progressive improvement of apnea index and ventilatory response to CO_2 after tracheostomy in obstructive sleep apnea syndrome. *Am Rev Respir Dis* 126:14-20, 1982.
5. Sullivan CE *et al.:* Reversal of obstructive sleep apnea by continuous positive airway pressure applied through the nares. *Lancet* i:862-865, 1981.
6. Weitzman ED *et al.:* Quantitative analysis of sleep and sleep apnea before and after tracheostomy in patients with the hypersomnia sleep apnea syndrome. *Sleep* 3(3/4):407-423, 1980.
7. Mahadevia A *et al.:* Effects of expiratory positive airway pressure on sleep-induced respiratory abnormalities in patients with hypersomnia-sleep apnea syndrome. *Am Rev Respir Dis* 128:708-711, 1983.

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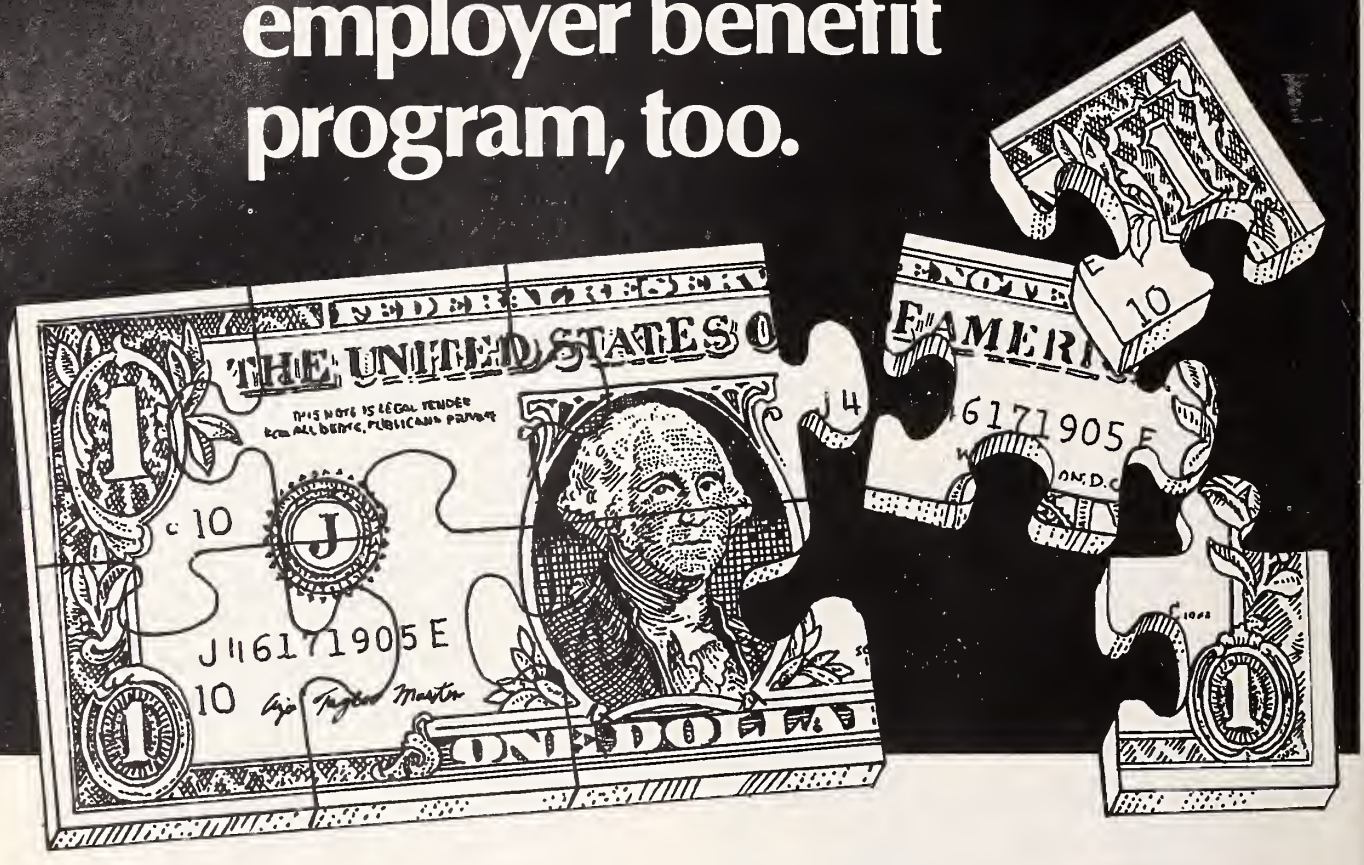
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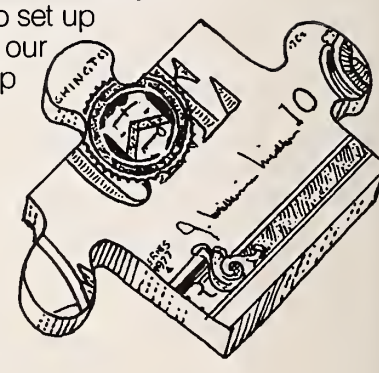
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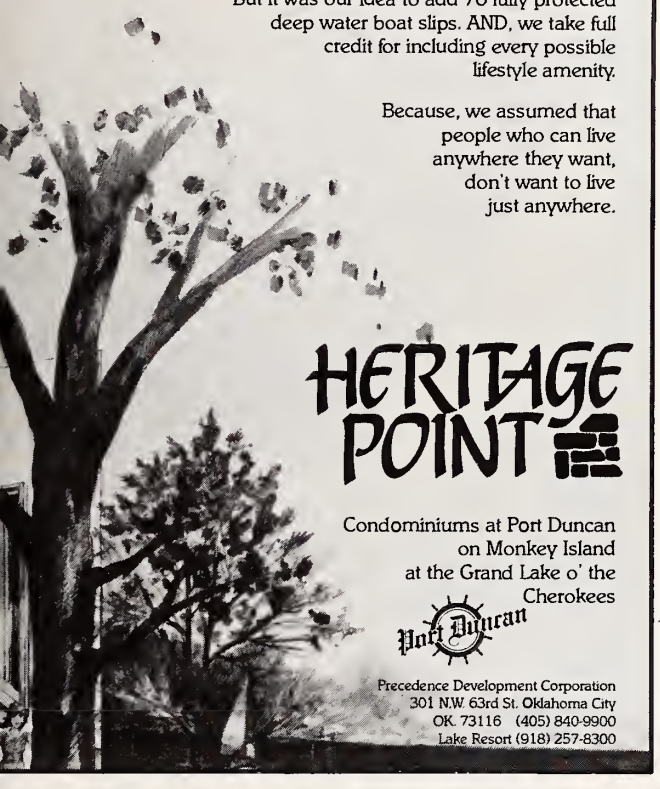
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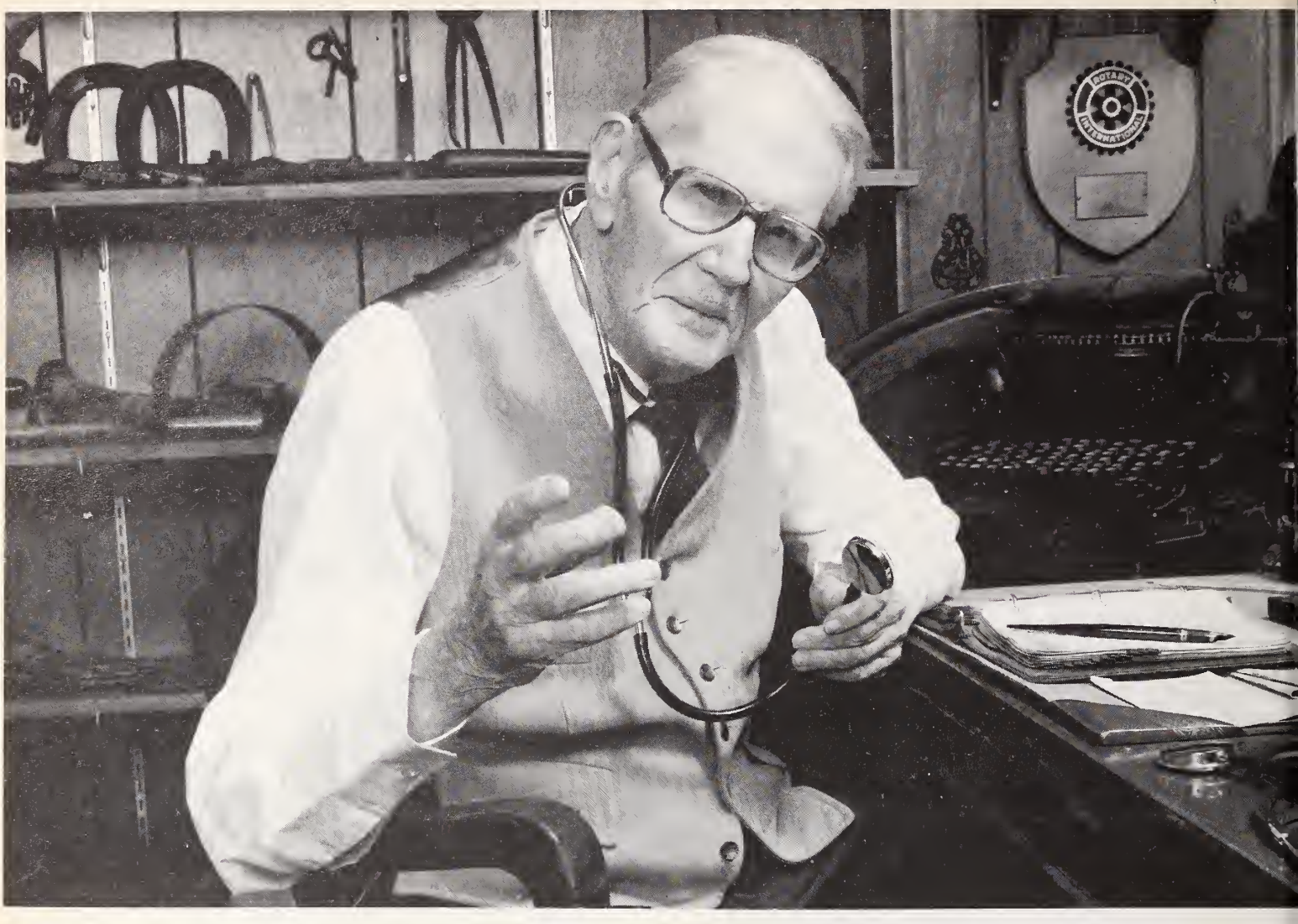
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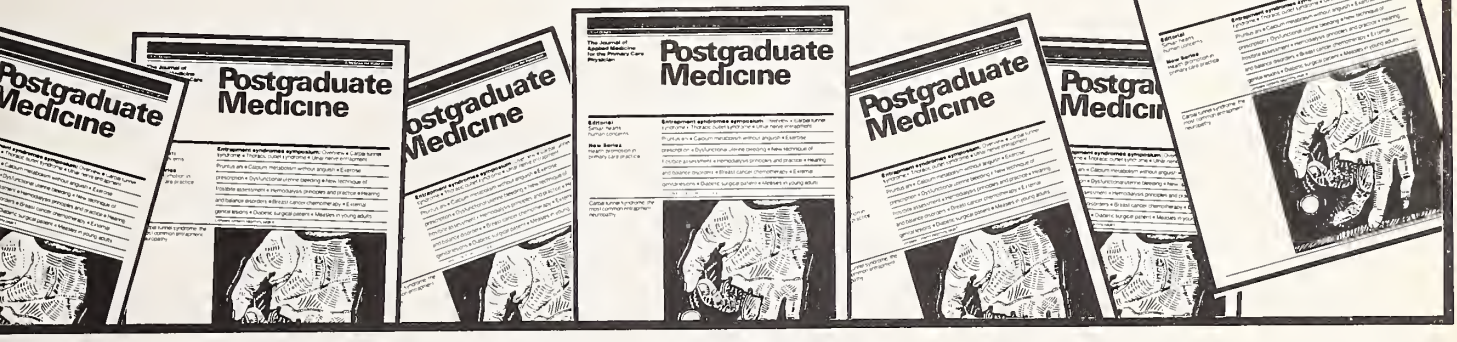
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Snakebite

(Continued from page 157)

Hyperkalemia, due to the rapid lysis of blood and tissue destruction, is a common problem.

Surgical intervention may be necessary in certain circumstances. The development of a compartment syndrome often requires a fasciotomy. Incision and drainage procedures, wound debridement, and skin grafting may also be necessary.

Steroids should not be given unless required to treat an allergic reaction to the antivenin. There is no evidence that steroids given soon after the bite are of benefit, and they may actually enhance the toxicity of the venom.

Cryotherapy is to be avoided. It can only enhance further ischemia with subsequent tissue necrosis in an area already severely compromised.

For the first 24 hours following the bite of the pit viper, oral intake should be limited to liquids. The toxin stimulates the smooth muscle of the gastrointestinal tract, and may result in vomiting and diarrhea.

A significant number of patients will develop serum sickness within one to four weeks of antivenin administration. Studies have shown that 30-75 per cent of patients develop this disorder if more than seven vials are used. High dose steroids rapidly tapered during a one week period is the treatment of choice.

Rapid collapse after envenomation has occurred due to an anaphylactic reaction to the venom in a previously bitten individual. The anaphylaxis must be managed first, followed by therapy for envenomation.

Previous snake bite does not result in immunity against the future effects of envenomation.

Prevention.

1. Avoid the known habitats of snakes.
2. Do not put hands or feet into areas you cannot see.
3. Wear protective clothing.
4. Avoid hiking alone in snake-infested areas, or at night.

Information concerning the treatment of snakebite from foreign species may be obtained at many large zoos, or through the Oklahoma Poison Control Center (405) 271-5454.

Suggested Reading

1. Durand LS *et al.:* Snake venom poisonings. *Comp Ther* 7:51, 1981.
2. Ennik F: Death from bites and stings of venomous animals. *West J Med* 133:463, 1980.
3. Minton II SA *et al.:* Answering the help snakebite call. *Patient Care* 13:52, 1979.
4. Russell FE: Snake venom poisonings in the United States. *Annu Rev Med* 31:247, 1980.
5. Watt II CH: Poisonous snakebite treatment in the United States. *JAMA* 240:654, 1978.

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Hyperparathyroidism

(Continued from page 147)

surgery, when performed by surgeons experienced in parathyroid surgery, has a very low morbidity and mortality as well as a low incidence of negative explorations.

In summary, we have reviewed our experience with hyperparathyroidism and outlined the evaluation and treatment for this disease. It is often an indolent and asymptomatic problem which if untreated can lead to significant morbidity expressed as renal and bone disease. Following appropriate evaluation, early surgical intervention is critical to reduce morbidity.

References

1. Heath H *et al.:* Primary hyperparathyroidism. *N Engl J Med* 302:189, 1980.
2. Fiske CH, Subarrow Y: The colorimetric determination of phosphorus. *J Biol Chem* 66:375, 1925.
3. Lumb GA, Stanbury SW: Parathyroid function in human vitamin D deficiency and vitamin D deficiency in primary hyperparathyroidism. *Am J Med* 56:833, 1974.
4. Mundy GR *et al.:* Primary hyperparathyroidism: Changes in pattern of clinical presentation. *Lancet* i:1317, 1980.
5. Hecht A *et al.:* Primary hyperparathyroidism, laboratory and clinical data in 73 cases. *JAMA* 233:519, 1975.
6. Jubiz W *et al.:* Circadian rhythm in serum PTH concentration in human subjects: Correlation with serum calcium, phosphate, albumin, and growth hormone levels. *J Clin Invest* 51:2040, 1972.
7. Purnell DC *et al.:* Primary hyperparathyroidism associated with hypernephroma. *Mayo Clin Proc* 57:694, 1982.
8. Schalz DA, Purcell DC: Asymptomatic primary hyperparathyroidism. *Mayo Clin Proc* 56:473, 1981.
9. Marx SJ: New insights into primary hyperparathyroidism. *Hosp Pract* March:55, 1984.
10. Editorial: Medical management of primary hyperparathyroidism. Lancet i:727, 1984.

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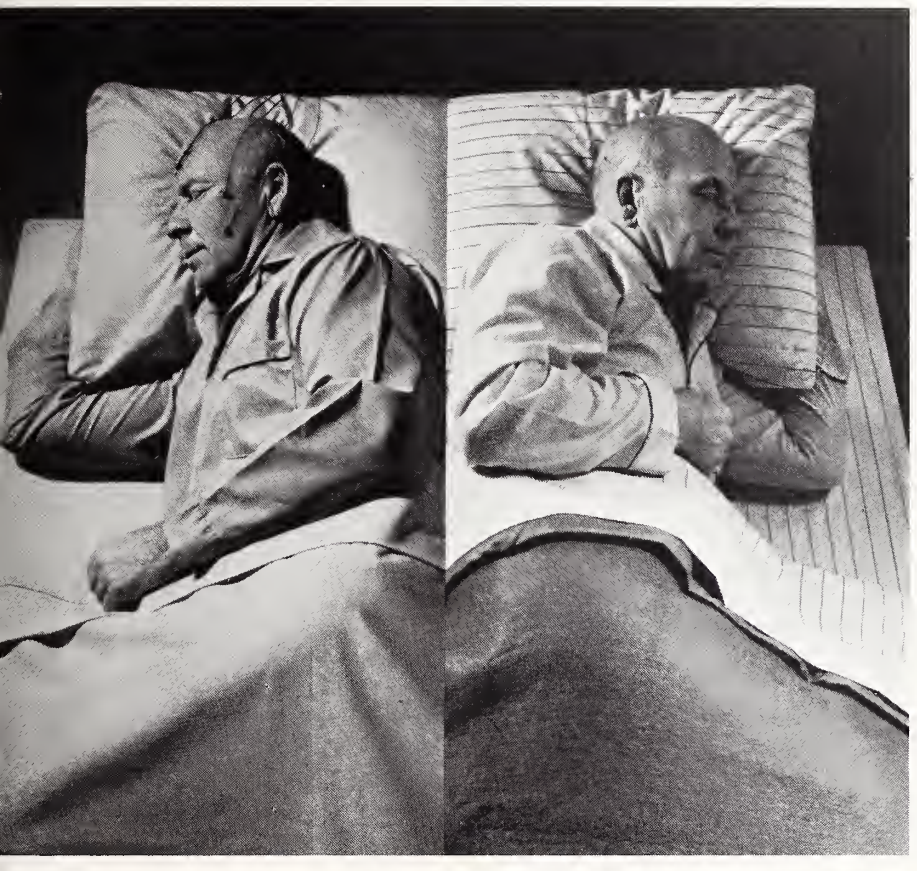
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References: 1. Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Genatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

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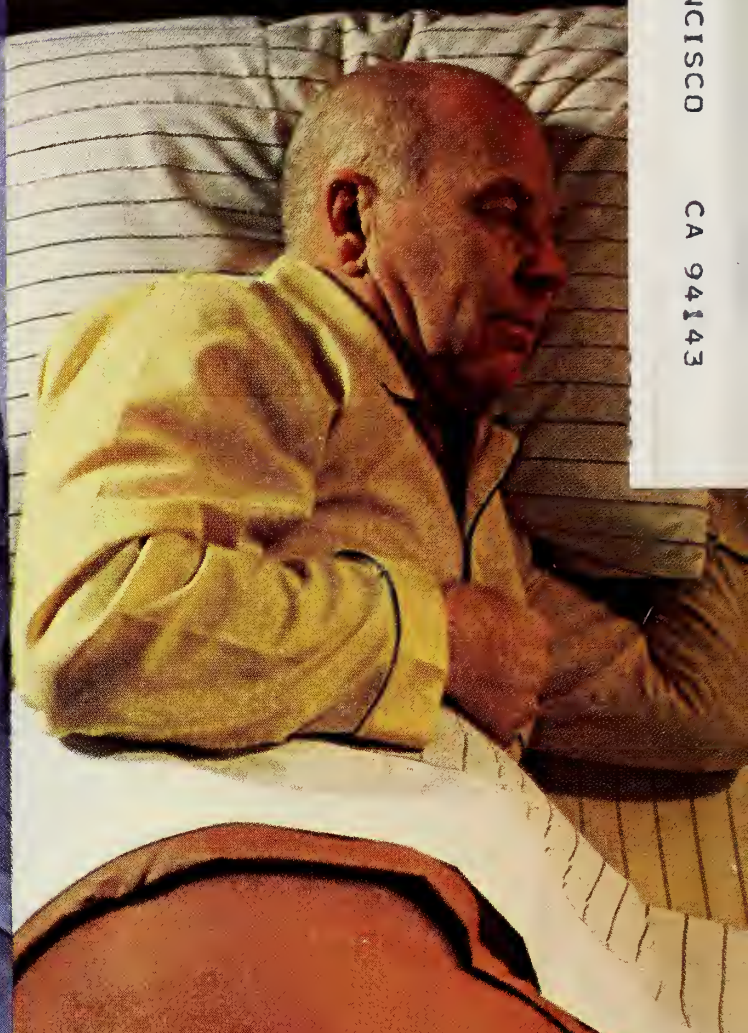
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KANSAS MEDICINE

Volume 86, Number 6, June 1985 ISSN 8755-0059



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AMA DELEGATE REPORT

Unified Membership

Editor's note: The 1985 House of Delegates adopted Resolution #85-12 that mandates unified county-state-national membership effective January 1, 1986. Beginning with this issue of KANSAS MEDICINE and for the remainder of 1985, a series of short messages to Kansas physicians will be presented by members of the Kansas AMA delegation.

The Kansas Medical Society, at its 126th Annual Meeting of the House of Delegates, passed Resolution #85-12 with only five dissenting votes. This resolution calls for Kansas to become a "unified state" by 1986. This means that when a physician joins the component county society, he/she also becomes a member of the Kansas Medical Society — as in the past — and now the American Medical Association (AMA).

In these times of rapid change — with intrusions into the practice of our profession by the federal government, insurance carriers, health care entrepreneurs, for-profit hospital corporations, and others — it is important that we respond to the challenges with a united and positive voice. The AMA is that voice! It needs and merits our monetary support and personal involvement to keep it an effective and responsible spokesperson for the profession. At present, about 70% of KMS members are AMA members. We need to make that 100%!

During the coming months we will acquaint you with the many benefits of AMA membership — benefits that far exceed the cost of the dues. One benefit is a 10% discount in AMA dues for active members from unified states, and this discount also applies to the reduced membership dues for members in their first and second years of practice.

Other benefits of unified membership will be addressed in this space in the coming months.

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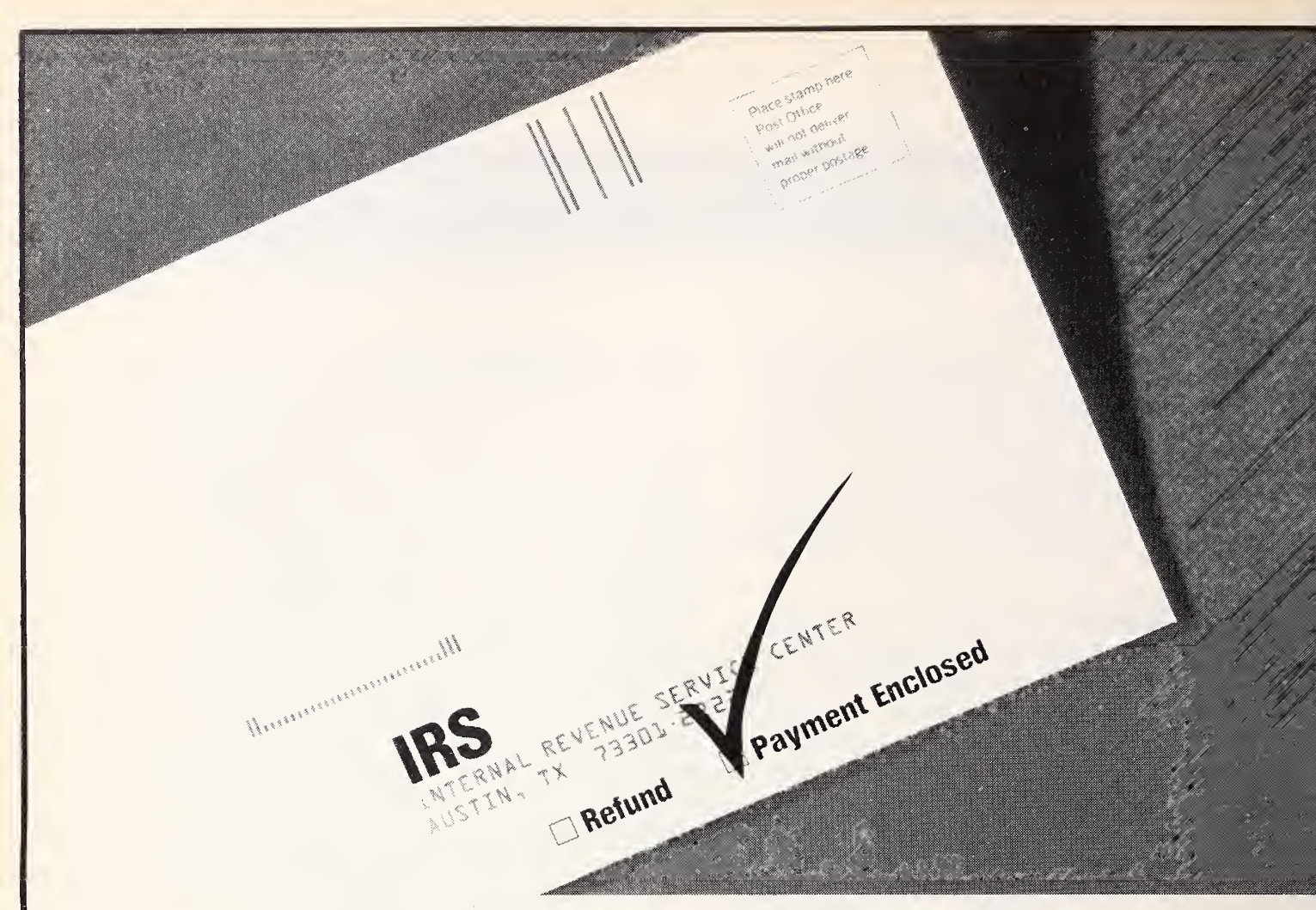
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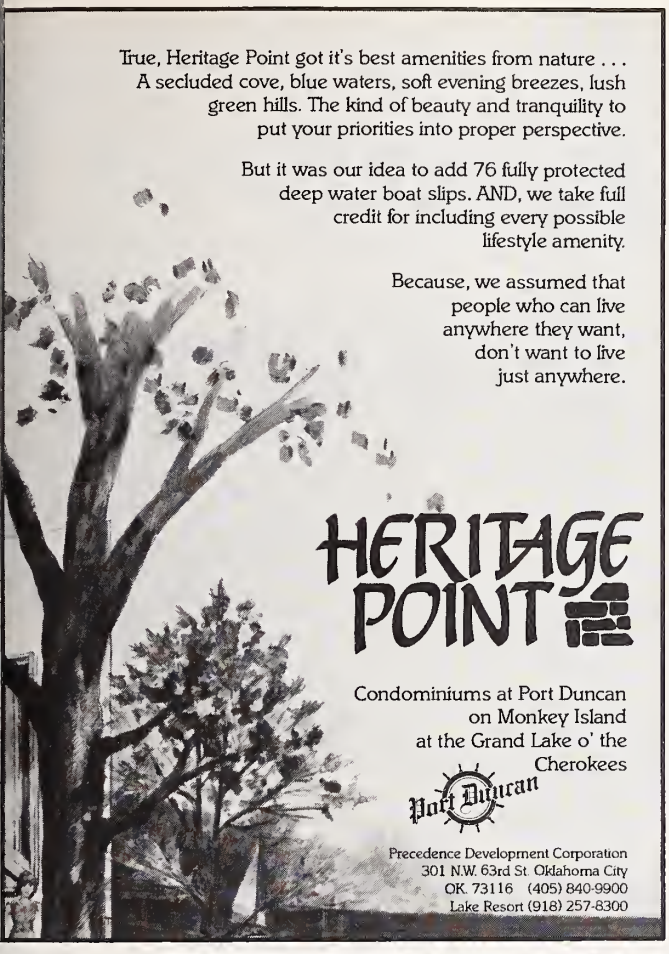
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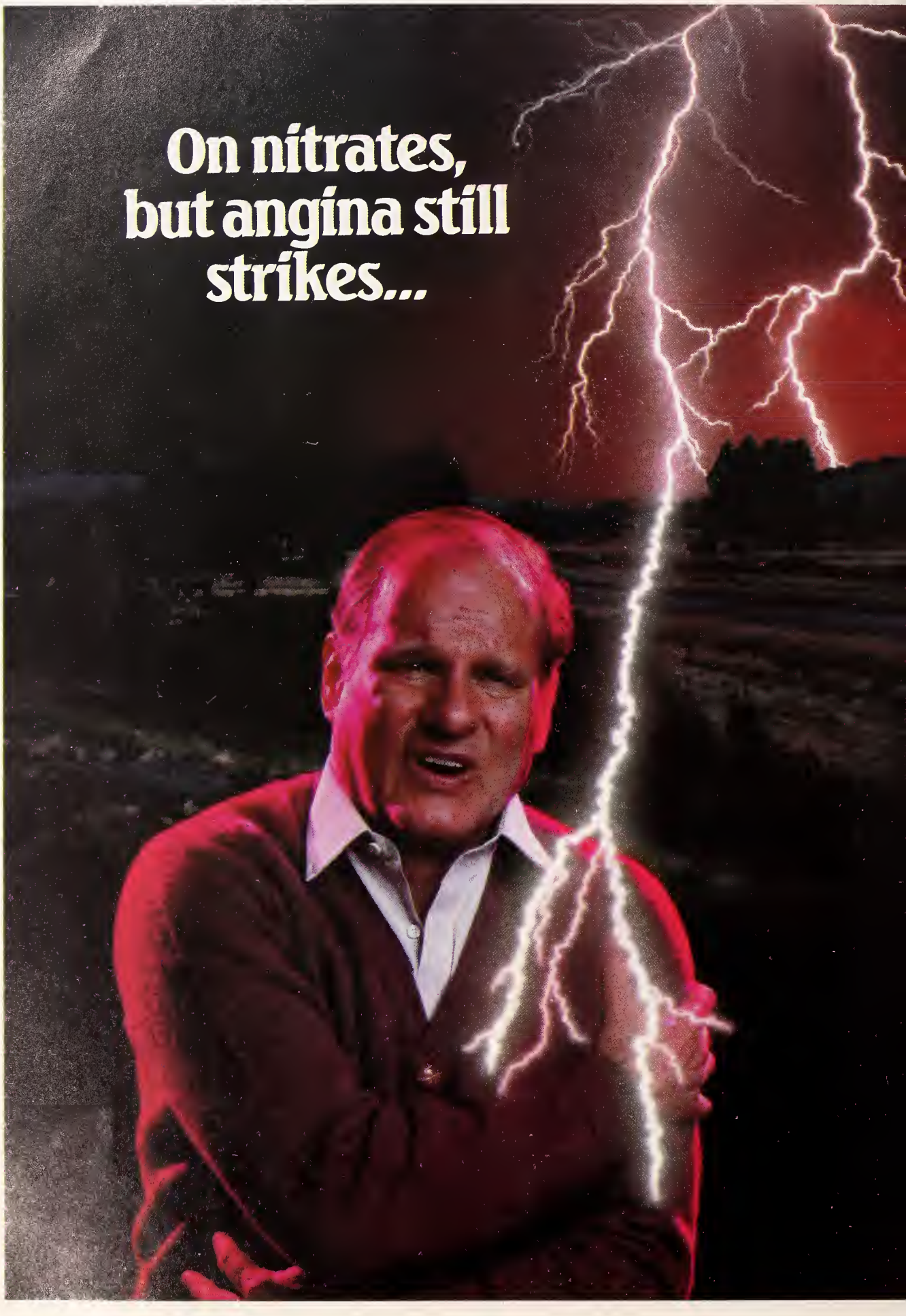


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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. 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Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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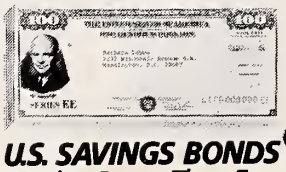


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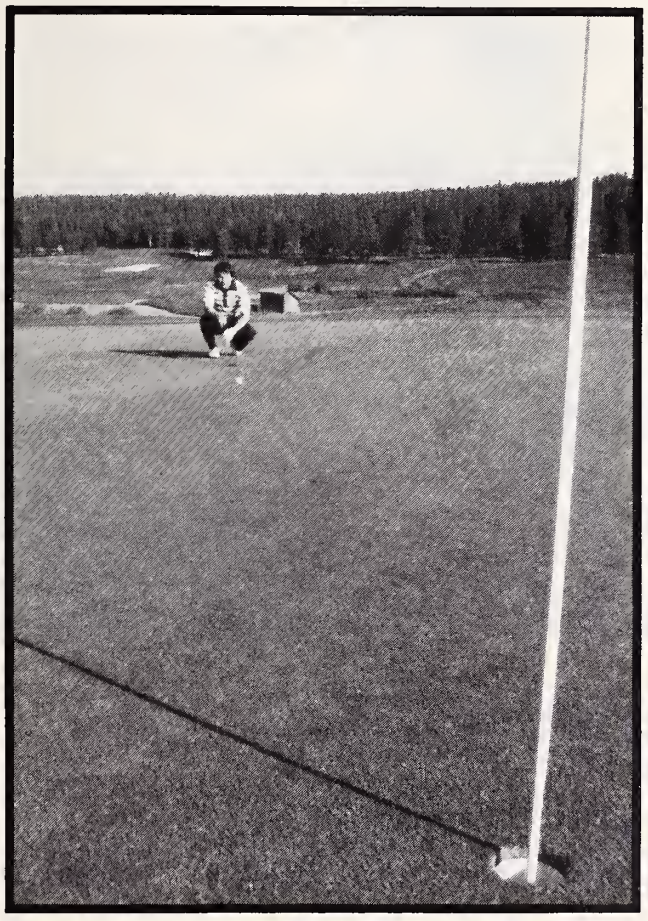


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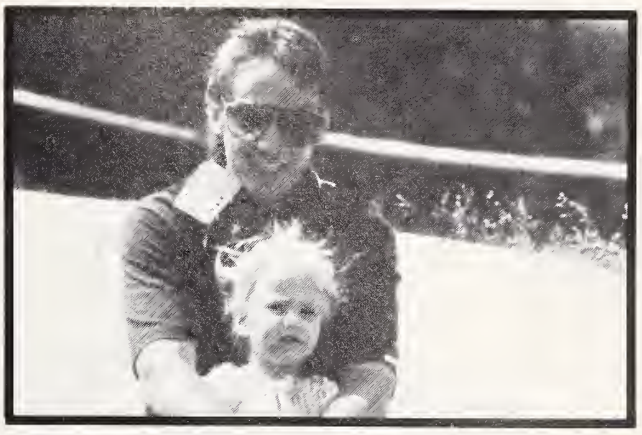
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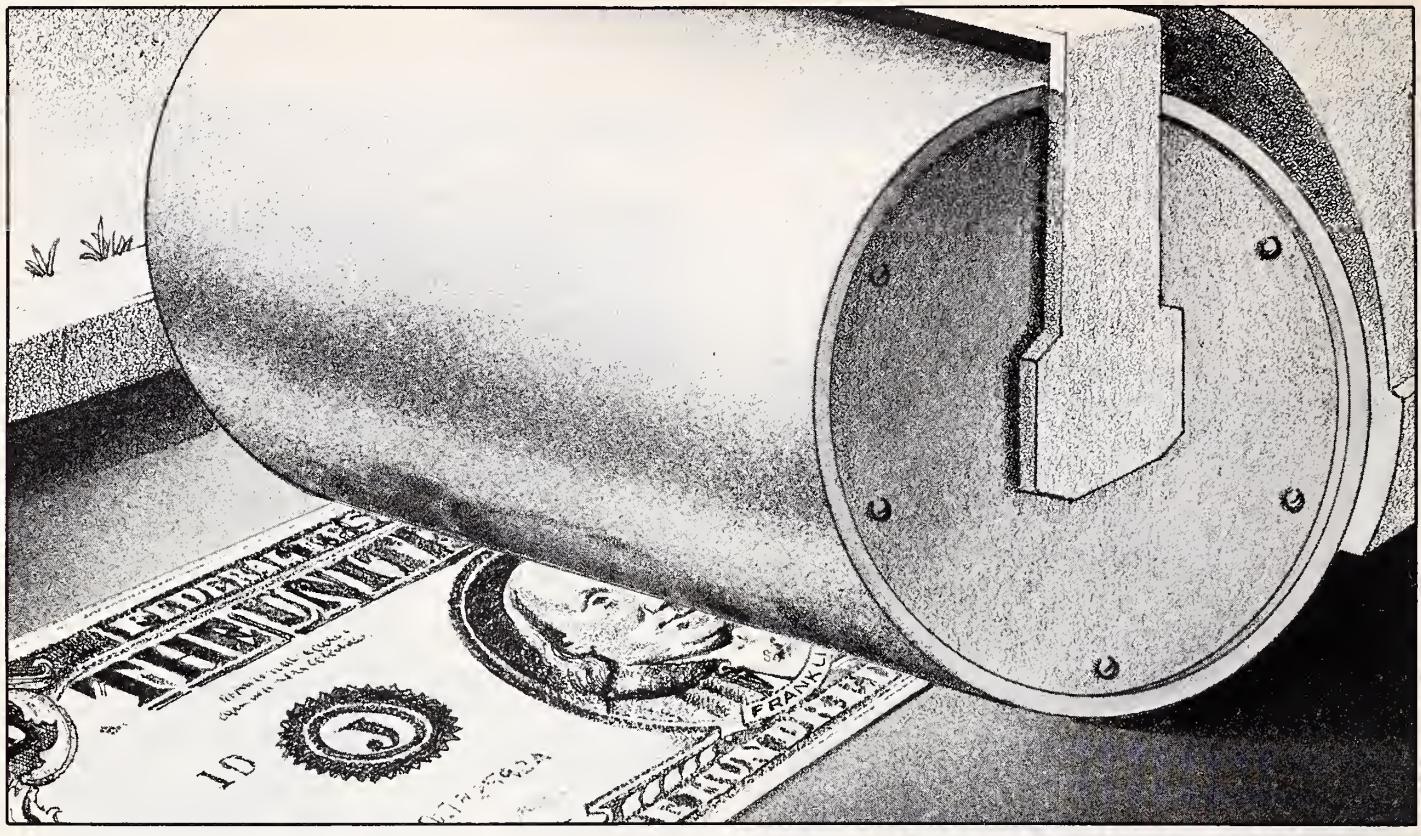
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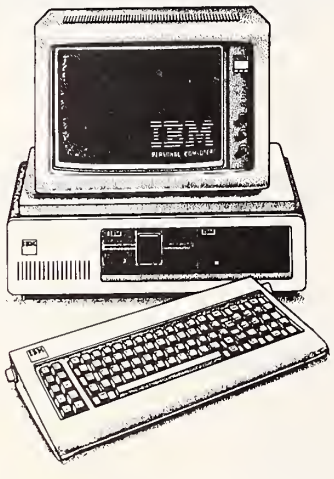
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SCIENTIFIC ARTICLES

"The Past is Prologue . . ."

BARBARA J. SABOL, R.N., M.A., * *Topeka*

In March, 1985, the Kansas Department of Health and Environment celebrated its 100th birthday. During this past century a number of organizational changes have occurred, leading from a Board of Health appointed by the governor with a part-time executive secretary and a budget of less than $5,000, to a Department of Health and Environment with a cabinet level secretary appointed by the governor with more than 500 employees and a budget of more than $40 million. The permanent executive officers since 1885 are listed at the end of this article.

For the first two decades of its existence the Kansas Board of Health had no full-time staff and an extremely small budget. Field work such as sanitation inspections and contagion control was carried out by the board member who lived nearest the site in question, by the state health officer, or by local county health officers appointed by county commissioners in each county. This was the beginning of a public health partnership between state and local government which exists to this day and through which most public health challenges are met.

The board did much of its work through standing committees. The titles of these committees give some idea of the scope of the early board's work. These 1889 committees included:

— Legislation, Revision of Rules and Regulations and Library
— Hygiene of Occupations and Railway Sanitation
— Epidemic and Endemic Disease and Quarantine
— Topography, Meteorology and Hygiene of Public Institutions
— Water Sources, Sewerage, Drainage and Disposal of Substances Injurious to Health
— Especial Sources of Dangers to Life and Health
— Adulteration of Food, Drinks and Drugs
— Heating, Ventilation, Lighting and Hygiene of Schools
— Vital Statistics, Registration, Meteorological Services and Nomenclature
— Finance

Board members were not paid a salary but were reimbursed for travel expenses.

It is amazing that a volunteer board, so understaffed and underfinanced, could accomplish what it did. These public health pioneers left us a legacy of dedication, courage, and imagination upon which the Department has continued to build. The Kansas Department of Health and Environment can successfully meet the challenges of the next 100 years only if there is the continued partnership with local health departments and an open comprehensive planning process.

With this in mind, in early 1985 the Department developed "Ten Propositions for the Health and Environment of Kansas." These propositions can serve as a guide for the Department for the next several years. Each proposition is important to carry out the charge that, while a century old, is still pertinent today, namely to protect the public health of Kansans and to safeguard the Kansas environment.

Ten Propositions

1. *An ounce of prevention is worth a pound of cure*. There has been a steady relative increase in morbidity and mortality from chronic disorders such as heart disease, cancer, cerebrovascular disease and diabetes. Evidence indicates that at least one-half of all chronic diseases are closely linked to lifestyle choices. In an effort to promote more healthful lifestyles, disease prevention efforts of the future must focus on individuals and how they choose to live as well as on circumstances and environments that support healthful choices. The work place is one key environment that influences health and lifestyle. The Department of Health and Environment has developed a work place effort including Project Health Promotion PLUS and Smoke Avoidance in the Work Place.

2. *The best way to assure a healthy start for Kansas infants is to provide adequate comprehensive prenatal health care*. Healthy infants at delivery

* Secretary, Kansas Department of Health & Environment
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are linked to early and comprehensive prenatal care which includes attention to nutrition, adequate medical and support services, education regarding labor and delivery, and prevention of alcohol and nonprescription drug consumption and smoking during pregnancy.

The Department will continue its promotion of and assistance to community-based programs designed to improve comprehensive prenatal services to pregnant women. Special emphasis will be placed on programs and services designed to reduce the gap between black and white infant mortality and to make comprehensive prenatal services available to low-income pregnant women. It is essential that increased public and private health efforts be directed to improved prenatal health care so that babies are born at term and in good health. The article in this issue by Schloesser and Hollowell identifies strategies to achieve this goal.

3. *The department is committed to protecting and serving the young children of our state.* The future of Kansas depends upon the nurturance, health, and optimal development of our children. The Department's programs are designed to promote adequate health care for children, including immunization against contagious diseases, proper nourishment, providing safeguards for children in and out of home care, and health screening and education programs in schools. We are increasing our emphasis on the early identification of children and infants at risk for handicapping conditions so that timely, appropriate intervention services can be initiated to give those children the best possible chance of growing normally. Through the Governor's Cabinet Subcommittee on Services for Preschool Handicapped Children, this Department works closely with the Departments of Education, Administration, and Social and Rehabilitation Services and the private sector to plan and implement a statewide system for handicapped children or children at risk for handicaps.

4. *Health promotion programs can improve the quality of life for older Kansans.* One goal of the Department is to encourage health promotion activities so that older citizens can lead not only longer lives, but long, healthy, and independent lives in their own homes and communities. Even with health promotion programs and activities some older citizens will require nursing home care. Those individuals who require this care must have care that meets standards that ensure their safety and comfort. The article by Corrigan, Morrissey, and Hollowell proposes a model to better address long term care needs for the older population.

5. *The department is committed to improving access to health care services for migrants, refugees, and other low-income persons.* For nearly 25 years the Department has operated a health program for migrant farm workers in Southwest Kansas, and services have been expanded to serve Asian and other refugees. These services will continue as the needs dictate.

6. *It is necessary that government, business, and consumers combine their efforts to explore, evaluate, and implement methods of controlling health care costs.* The rapid acceleration of health care costs is a major public concern. Costs have nearly doubled every five years since 1955. This threatens the access to health care for individuals with marginal and fixed incomes and who are underinsured or uninsured. No single governmental or private entity has "the answer" to this complex problem. There must be a thorough understanding of the factors that contribute to the escalation of cost so that appropriate remedies may be instituted. The Statewide Health Coordinating Council (SHCC) has made this concern a priority.

7. *There should be no land burial of hazardous waste.* Kansas cannot afford to risk contamination of its precious groundwater by land burial of hazardous wastes. Groundwater is a valuable and nonreplaceable resource to be protected by all means available. In 1984 Governor John Carlin recommended and in 1985 the Kansas Legislature enacted a law banning the underground burial of hazardous wastes in Kansas — a fitting Centennial landmark!

8. *The department is committed to ensuring compliance with environmental statutes and regulations.* Through the rapid acceleration of science and technology, we have acquired new power to adversely transform our environment in countless ways. The rigorous protection and improvement of our environment is a major issue that affects the well being of the citizens as well as the state's economic development.

The Department works with industry whenever possible to effectively protect the environment and whenever necessary has imposed appropriate sanctions to secure compliance. When there is conflicting information our approach is to take the alternative most protective of the environment.

9. *The effective protection of our water resources requires a fully integrated groundwater and surface water program.* The people of Kansas for almost a century have been concerned about the quality of water and adequate supplies. With increasing demand has come a growing concern for good quality

management. Assuring an adequate supply is not sufficient — it must also be a safe supply. Kansas needs to move progressively forward to improve its water protection of surface and groundwaters to ensure a high quality of life for our citizens by assuring:

— better water quality in streams, lakes and groundwater;
— more surface and groundwater support designated uses;
— continued progress by industry and municipalities in providing adequate waste-water treatment.

Certainly, much remains to be done. Continuous vigilance is required to control pollution of surface or groundwater. The past decade has laid a solid foundation in water pollution control and provision of safe drinking water. The progress made toward cleaner water will serve us well as we build on past accomplishments in the years ahead.

Building on our solid foundation, we will concentrate our immediate efforts on groundwater quality protection without relaxing our vigorous surface water control programs. An integrated groundwater protection strategy is presently under development. This strategy will be jointly developed by all Kansas groundwater regulating agencies with public participation. It will identify: sources of pollution; federal and state statutes and regulations to deal with sources of groundwater pollution; and assess the adequacy of all programs dealing with groundwater.

It is our goal to achieve progress in protecting the quality of groundwaters such as we achieved during the last decade in surface water quality control.

10. *The department is committed to protecting the public from the risks of air pollutants, and toxic, hazardous and radioactive wastes.* The Department of a century ago did not face the problem of potentially hazardous and highly toxic industrial by-products and waste materials. Today, it is one of the most significant problems.

Conclusion

The history of this Department in conjunction with local health departments and private practice medicine is enormously rich in innovative and progressive public health programs. This century of progress in Kansas has set the stage for the continuing excellence of the Department. The goals are similar, the programs have changed and will continue to change to meet the challenges of the next 100 years.

Acknowledgement

Virginia Lockhart, Bureau of Community Health; Joseph G. Hollowell, Jr., M.D., Director, Division of Health; and Gyula Kovach, Bureau of Water Protection, Kansas Dept. of Health & Environment, assisted in the preparation of this manuscript.

Health Department Executives

Executive Secretaries — Board of Health

1885-1891 J. W. Redden, M.D.
1891-1893 M. O'Brien, M.D.
1893-1895 Henry A. Dykes, M.D.
1895-1897 Thomas Kirkpatrick, M.D.
1897-1899 H. Z. Gill, M.D.
1899-1902 W. B. Swan, M.D.
1902-1904 Charles Lowry, M.D.
1904-1923 Samuel J. Crumbine, M.D.
1923-1925 Milton O. Myberg, M.D.
1925-1937 Earle C. Brown, M.D.
1937-1941 Fred P. Helm, M.D.
1941-1951 Floyd C. Beelman, M.D.

State Department of Health — Created in 1951

1951-1958 Thomas R. Hood, M.D.
1958-1961 Geoffrey Martin, M.D.
1961-1967 Robert H. Riedel, M.D.
1967-1969 Hugh Dierker, M.D.
1969-1973 Edwin Lyman, M.D.

Kansas Department of Health and Environment — Established 1974

1974-1979 Dwight F. Metzler, C.E.
1979-1983 Joseph F. Harkins, M.P.A.
1983-present Barbara J. Sabol, R.N., M.A.

The Birth of the Boards

DAVID E. GRAY, M.D., ***Topeka***

THE NATIONAL ferment that prevailed after the Civil War found expression nowhere more than in Kansas. Questionable though the procedure might be medically, the blood-letting that accompanied the state's birth was followed by an invigorated growth in all dimensions. Cattle and crops were moving eastward, people and railroads were moving westward, and the character of the new state was being consciously established by the tide of new inhabitants. The original inhabitants had their own interpretation of "Manifest Destiny," and made their objections known with varying degrees of vigor, but ultimately were impotent to hold their ground either figuratively or literally against the tide.

Physicians who came to the new state were worthy participants in the process of developing this character — not just in coping with the sickness and injuries that accompanied the immigrants' adjustment to the new living requirements. They brought, too, a level of intellect that contributed much to the tempering of the state structure as they participated actively in social and political developments. And inevitably their sense of professional community prompted them to form their own small but promising organization, the Kansas Medical Society.

If this act indicated high purpose on the part of the participants, the times were hardly propitious for a healthy neonatal period. The organization's territorial charter, even today a matter of some pride, put a governmental blessing on the effort, but the intervention of the war delayed any definitive development. Without a firm basis in dedication to personal and public service inherent in the profession, the initial effort might well have atrophied. In fact, the same strength of medical dedication which prompted its founding gave all the more impetus as it — and the state — grew.

To this picture must be added the internal ferment that was pervading the medical profession. The struggle to adjust to the concept that many diseases could be the result of the presence of microorganisms produced broad and deep conflicts ranging from fanatic acceptance to fanatic rejection. Emerging methods of anesthesia as well as efforts to control these minute enemies were pressing improvement of surgery's promise. Medical education was moving from primary dependency on preceptorship of widely varying quality to primary dependency on institutional organization, hardly, at this stage, less varying in quality.

It was finally the unrelenting demonstration of success of the new efforts based on such innovations, personal and public, that led to the acceptance and growth of medical service even as the state offered social and political growth. Moreover, the medical and public conviction that the western climate had a salutary effect on many chronic illnesses accounted for a tangible influence on the pioneer traffic to and through the state.

But if the fertile growth conditions, both professional and public, enhanced the development of a strong and productive medical population, it also fostered the appearance of a broad variety of self-proclaimed "practitioners" who relied on the needs of a sparsely distributed populace, as well as the ever-present gullibility of that populace, to promote their fabulous schemes and nostrums. So it is not surprising that the small group of legitimate physicians, mindful of public responsibilities and jealous of their own qualifications and status, would quickly address the problem of at least controlling, preferably eliminating, such individuals. Nor is it surprising, then, that the society's efforts to obtain statutory control of both public health and professional quality should be directed toward an act that would combine both facets of medical service.

The first three meetings of the Kansas Medical Society — 1859, 1860, and 1861 — were primarily organizational, but a Code of Ethics, established in 1859, was obviously high on the list of concerns. It is also apparent that the exigencies of the war effort precluded any effective progress, and no other meeting was recorded until 1866 when more formal organization was accomplished with the inevitable appointment of committees (although the total membership was less than some present day committees). It is noted, however, as a sign of growth as well as professional intent that in that year, the Board of Censors was ready to report favorably on 26 applicants for membership. Perhaps in reaction to those unwanted individuals of little or no medical qualification, the society saw the matter as a clear-cut issue: those deemed qualified by schooling and prac-

Address reprint requests to Dr. Gray, KANSAS MEDICINE, 1300 Topeka Avenue, Topeka KS 66612.

tice method for membership in the society were "regular" practitioners, and those not acceptable were, *ipso facto,* "irregular" and to be shunned.

The medical society was now at that point of realism when it must not just accept but seek some governmental control in order to secure statutory power to enforce its standards. (For some years, it was to run up against the legislative attitude that as long as the members had their own requirements for membership in their own group, that was all that was necessary.) At the same time, although physicians were quite properly called upon for advice and assistance in whatever public health programs were attempted locally, there seems to have been no interest within the legislature to make the process effective by statutory support.

The legislature did, in 1869, agree that the registration of "vital statistics" — births, marriages, and deaths — was a good idea and gave its blessing accordingly, but that is all it did. There was no provision for state collection or utilization of the data, no control over the process itself, and no compulsion beyond individual physician interest. If the legislature felt preoccupied with matters it considered of more importance, the society's intent to run a clean house is demonstrated by the fact that the Board of Censors, after reviewing charges brought by various members had, by 1873, brought about the expulsion of three members — chiefly for being suspiciously cozy with irregular practitioners.

The *Transactions* of the Kansas Medical Society through the 70s reflect an annual effort to get a medical registration law as well as a stronger public health law, partly in response to the pressure from the growing American Medical Association. The frustration of the society at its continued failures resulted in the caustic comment of H. S. Roberts of Manhattan in his 1877 Presidential Address: "The fact of men desiring legislation of purely scientific purposes and advancement of public health, with no sordid money motive back, is beyond the ken of the average Kansas Legislature, and when has it risen above this monotonous level?"

Meanwhile, followers of two other medical philosophies — eclecticism and homeopathy — were increasing in number and it became necessary to include them in an uneasy triumvirate in the effort toward practice regulation. Finally, in 1879, a bill was passed that gave more substance to public health controls and met the registration and examination problem by establishing three boards — one for each of these groups — consisting of seven members each, in the hope of pleasing everyone. Each organization would select its own members and oversee certification of its own applicants. Anyone who sought to practice medicine in the state had to hold a certificate from one or another of the boards.

The law was short-lived. The Supreme Court promptly declared the act unconstitutional since it conferred corporate powers on the three societies and no others. An interesting sidelight, however, is that the Attorney General, Willard Davis, initially attempted to declare that the Kansas Medical Society was without power since it held a territorial charter and any such power had ceased when the territory became a state. The society could at least feel some comfort in the response of the Supreme Court that ". . . the Kansas Medical Society is a live institution; that it is perpetual and immortal, so far as the law can create immortality."

In the ensuing years it became increasingly apparent that a law covering both precepts of medical service — public health and medical registration — was a political impossibility. A degree of success can be recognized, in view of this atmosphere, in the fact that in 1885, the legislature did establish a State Board of Health, and although the act added little to what already existed, it is this date that is remembered as marking the real beginning of the department. The board consisted of nine members, all of whom were physicians: G. H. P. Johnson, President; G. H. Guibor, D. Surber, D. W. Stormont, J. Milton Welch, H. S. Roberts, J. W. Jenny, W. L, Schenck, and T. A. Wright. The first secretary was J. W. Redden. The accomplishments of the board and of the secretary, however good the intent, were limited by both internal and external factors. There seems to have been little in the way of guidelines to assist the early activities. Although subjects of public health interest formed the topics for papers at the Kansas Medical Society's annual meetings intermittently, even the society apparently took no official action to firm up the board's functions. The budgetary limit set on the department was $5,000, one clerk-secretary at $40 a month was provided as the total staff (and with little enough to do as it happened), and the secretary was only part time, an arrangement not conducive to deep dedication when the necessity arose to attend to private practice.

Although these early years were not without effect in maintaining the basic structure and philosophy of such a department, another ingredient was necessary to realize its highest purpose: a mover and shaker. This, however, was not to be until 1904 when that small giant, Samuel J. Crumbine, M.D., would move in to make public health history nationally and

internationally. But if his tenure was to be the realization of outstanding public health efforts and the time from which many would count the real establishment of an effective state health department (and he was not above fostering that idea), the long and frustrating effort to set the stage cannot be overlooked.

In the other area, medical certification, the allopaths continued what appears to have been an alliance of necessity rather than conviction with the homeopaths and eclectics, the latter being at least unpredictable in maintaining any unanimity of decision. When the legislative chips were down, they seem to have followed only what was to their own advantage. Finally, in 1895, it did appear that the elements necessary for passage of a medical practice act were in place: agreement (sufficient, at least) among these differing philosophies and a favorable nose count among the legislators.

At the last minute, however, the effort was again shot down. The eclectic member decided the current regulations were sufficient and withdrew from the fight. The patent medicine companies, fearful of the effect on their sales, mounted intensive lobbying efforts. The Populists, never in favor of the act, were growing in strength. And then as now, some of the legislators changed their votes at the last minute. At least one of the factors in this seems to have been that some of the sparsely settled areas relied on one or another of the "irregular" practitioners, and their representatives got the message that that was preferable to no service which might have resulted from the act.

Those familiar with the problems of promoting legislative action cannot help but admire the persistence of the perennial committees appointed by the Kansas Medical Society to continue the struggle. There was, however, a gradual change of power. The homeopaths were diminishing as they were increasingly absorbed into the allopathic philosophy. The eclectics were coming around to amenability to a single board, although they would persist for a number of years (long enough, at least, to produce John R. Brinkley) before passing into the annals of medical history.

So it was that in 1901, a State Board of Medical Registration and examination was finally established. The legislative blessing is contained in Chapter 254, Session Laws of Kansas, 1901. Its composition as indicated in the Certificates of Authority included seven members: G. F. Johnston, Lakin; E. P. Hatfield, Grenola; E. B. Packer, Osage City; S. W. Williston, Lawrence; O. F. Lewis, Hepler; D. P. Cook, Clay Center; and Henry W. Roby, Topeka. In the absence of any prior organization, a form of parliamentary purity was maintained by having the incumbent Secretary of the State Board of Health, W. S. Davis, M.D., preside long enough to elect Dr. Williston temporary president and Dr. Roby temporary secretary. Dr. Johnston and Dr. Packer were promptly elected permanent president and vice president respectively, while Dr. Roby retained his role as secretary on a permanent basis. His qualifications may have included his residence in Topeka since the board's expenses for this first meeting — per diem and travel — came to $172.41, of which Dr. Roby's share was only $6.00.

One of the first actions seems to reflect that the members, although all identified as MDs, apparently had differing academic loyalties as it was agreed that "members from different schools" would each draw up "lists of acceptable schools of these practices." Each member was assigned one subject for which he had responsibility for developing and grading the examinations which included anatomy and histology, chemistry, obstetrics and gynecology, pathology, physiology, bacteriology, and surgery.

So the turn of the century marked the accomplishment of a degree of medical maturity — some 50 years in coming — for the state of Kansas. A state board of health was alive and soon to be a source of pride for all (except the miscreants who would suffer at the hands of the soon-to-arrive nemesis). A board of medical registration and examination was providing a base of legal control over medical practice. And the Kansas Medical Society was responding to expanding roles in every area of medical care, both state and national.

Whether any of these groups as they were then — parent or siblings — would recognize their current forms is doubtful. But such is the effect in a world where problems, like the coins in the mythical purse of folklore, seem to increase tenfold for each one removed.

Changing Concepts of Public Health

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ONLY 16 years after Massachusetts became the first state to establish a state health department, the Kansas Legislature established its own State Board of Health on March 7, 1885. Massachusetts had been a state for nearly a century when it established a department to protect the public health while Kansas was a young, vigorous, and irrepressible 24-year-old when it took this step. J. W. Redden, M.D., was named the first secretary.

Almost from its beginning the new State Board of Health was a national leader in public health. This became particularly true when Dr. Samuel J. Crumbine was appointed part-time secretary of the board in 1904, and later its first full-time secretary on July 1, 1907. Those who have been fortunate enough to follow in the footsteps of these imaginative, innovative, and far-sighted public health officials have been challenged to keep alive their traditions of public health leadership.

The old annual reports of the Kansas State Board of Health are fascinating. They are a history of the development of this state and a report on the progress of the technology of public health. They give a gripping account of the daily struggles of state and local officials responsible for the protection of the health of the citizens of the young state.

There is evidence throughout the reports of a terrible fear of smallpox, and efforts to track down and contain epidemics. The fifth annual report of 1889 tells of a butcher who traveled Woodson County selling meat and unknowingly, also smallpox. When he reached home he was "sick with fever, unable to care for his horses." The dread eruption appeared on the third day. "It is hard to predict the possible number that may be attacked within the next few weeks," reported the health officer. The health officer also pointed out that the recent Attorney General's ruling that the State Board of Health did not have the power to quarantine, but that cities did, did not afford protection to "this little village (Piqua) and its surrounding country from the spread of contagion." From July 13, when the first case was diagnosed, until August 16, 27 cases were reported and "one death Sunday night at 10:40, buried Monday, 2AM."

Besides smallpox the board worked to contain outbreaks of whooping cough, rabies, typhoid, diphtheria, strep throat, chickenpox and measles, and provided local health officials with assistance in differentiating between diseases with similar symptoms such as strep throat and diphtheria. There was no laboratory assistance available to help with diagnoses. Most often it was a matter of judgment, patient history, and physician experience.

Pleas for help of this nature are illustrated by a telegram from a local health officer in Piqua, "Now doctor, send me a man who can recognize variola (smallpox) when he sees a typical case. Two new cases yesterday, a total of 14. Act at once!"

The early board recognized the necessity for specific laws which would clarify the authority of the board to deal with matters related to the spread of disease. They prepared a supplemental bill for submission to the Legislature in 1889, which would "confer full and complete power and authority upon the state and county boards of health, and which would enforce under penalty all necessary rules and regulations in sanitary matters for the prevention, regulation, and suppression of epidemic, contagious and pestilential diseases, check the spread of epidemics, regulate the construction and discharge of sewers, protect the purity of running streams, and generally promote the health of the people." The bill never got out of the Senate committee.

This failure caused problems later with efforts to control the spread of smallpox. When asked for an opinion, the Attorney General had ruled that the State Board of Health did not have the authority under the law to quarantine but that this authority could be given to city governments. Thus the state could not quarantine during an epidemic but had to

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rely upon city officials who were sometimes reluctant to take action. Health education literature was widely distributed as reference is made to the "preparation in pamphlet form of 1000 copies of 'the Disposal of Sewage,'" and to pamphlets sent out on smallpox.

Often that was the only assistance, other than encouragement, the state health officer with no staff could provide to local communities. Recognizing this, Dr. Redden wrote in 1889 about the local health officer: "As a general rule he labors without funds, without legal powers, without aid, and without sympathy."

However, at that time there were 86 county health organizations, doing "valuable work for the benefit of the people" and the other 20 counties were doing some work in distributing literature and pamphlets, thus "educating the people to appreciate the value of preventive medicine." (Note: Garfield County in 1892 was declared by the Supreme Court to have been illegally organized, and in 1893 it was annexed to Finney, making our present 105 counties).

From its beginning, the new board of health was concerned about the sanitation of the environment in Kansas. It was recognized early that dirty polluted water was a source of much illness such as typhoid fever, and that flies and rodents were spreaders of disease through food contamination.

The board expressed dismay at the state of pollution of the nation's rivers noting that "in the Missouri River, four cities cast 36,000 tons of garbage, 22,400 tons of night-soil, and 31,600 dead animals in one year."

Sensing that a bill itself would not pass, the board succeeded in having an amendment added to another bill which was passed and which gave "cities power and authority to regulate the purity of running streams and water supplies and preventing the emptying of sewers into running streams within two miles above any water supply company."

The new board of health was concerned about the collection of vital statistics, and one of the duties of the local health officers was to report the number of births and deaths each month, as well as the number of contagious diseases identified during the reporting period. For a number of years these data were laboriously kept by hand on inventory sheets still retained in the archives of the department. Banks of computers now handle the compilation of data accumulated from birth and death records. Nearly 7,000,000 vital records are now stored in the salt vaults near Hutchison, accumulated since the vital statistics law was passed in 1911.

During its first year, the board was concerned about the discrepancies that seemed to exist in counties between the number of deaths reported and the number of "burial cases" sold, and discovered that physicians had 30 days to report deaths but undertakers "have but seven days to report sale of burial cases," thus on a monthly basis the two sets of data never agreed.

Documented in the fifth annual report of the Board is evidence of the first concern for the regulation of the practice of medicine and surgery in the state with the development of a bill for consideration by the legislature. A dispute killed the bill when it was amended to create a new licensing board rather than place the responsibility with the Board of Health. One senator complained that there were too many boards already and he aimed to "eliminate a few."

In February 1889, the Kansas Legislature, at the urging of the State Board of Health and the State Sanitary Association, passed a law prohibiting the selling, giving, or furnishing of any tobacco or narcotics products to a minor under the age of 16. This problem is still discussed in one form or another by the legislature some 100 years later.

The board had responsibility for the inspection of public institutions and public buildings such as "poor houses," "jails" and "homes for orphans," and wrote regular reports on the sanitary conditions of the premises and the care and condition of the residents. It was also responsible for monitoring weather conditions and laboriously kept detailed data regarding temperatures and rainfall conditions.

In reflecting upon the present Department of Health and Environment compared with the parent agency of a century ago, one is struck by the similarities of problems. Both had and have as their major reason for being "the protection and promotion of the health of the people of the state." Both had and have a concern about the quality of water, the treatment of sewage, the control of disease, the sanitation of food, purity of drugs, health education, and collection of vital records.

The early board relied, as does the present department, upon legislative backup and direction, upon public support and understanding, and upon consultation and advice from diverse professional groups, especially the medical and environmental community.

The most dramatic changes in the pattern of public health today — in contrast to that of a century ago — are in the areas of maternal care, infant survival, chronic diseases, care of the aging, and changing

environmental problems caused by our "high tech" economy.

The time and resources of the early board of health were expended in trying to control the spread of infectious diseases through quarantine, public education, and improved sanitation of food and water supplies and sewage disposal. Today, we are no longer particularly troubled by widespread outbreaks of infectious diseases although continuous vigilance is necessary to keep immunization levels from dropping to dangerous lows. An occasional disease which appears to be entirely new or a variant of an old enemy occasionally appears to concern us as well. Smallpox — which brought so much grief to the early pioneers — has now disappeared from the world except for the few isolated specimens maintained in research laboratories. Programs of infection control are now primarily directed toward maintaining high immunization levels and swift epidemiological investigation of the sources of disease outbreaks. Laboratory capability also affords swift and accurate assistance in diagnosis, which greatly aids in the control of such outbreaks.

With a sharp decrease in infant and early childhood deaths, more and more people live to adulthood. This has led to a congregation of people in the state past the age of 60 years with the resulting age-related chronic diseases such as heart disease, cancer, cerebrovascular diseases, and arthritis. While the life expectancy of a person past the age of 70 years has increased during the last century by only a few years, the total life expectancy at birth has increased by more than 30 years. The diseases that are the killers now are those related to lifestyles such as smoking, alcohol abuse, poor food choices leading to diets high in cholesterol, fat, sodium and sugar and low in fiber, and to lack of exercise and high stress levels. Some researchers say that as many as one-half of all chronic diseases are caused by high-risk lifestyles. In an effort to delay the onset of premature disability and death, the department has developed and is implementing a health promotion program for state employees and is planning programs for the elderly and the school-age population.

It was a hard fact of early pioneer life that families could anticipate the death of at least one infant under the age of 2 years. It was also a hard fact that women facing childbirth with limited or no medical care at the time of delivery also faced a high risk of not surviving the birth of a baby. Through the years infant death rates have slowly and steadily declined. Improved sanitation, better prenatal care, immunizations and sophisticated facilities for the care of high-risk babies have brought about this trend. Public health now looks toward improving even more the care of fragile infants and high risk mothers by education programs for young women regarding the self-imposed risks of smoking and drug and alcohol use, and promotion of services for low income pregnant women and young children.

From its inception, the environment and its quality has been a concern of the department. At first, it was a frantic effort to understand the relationship between polluted water and contaminated food and the spread of contagious diseases, and then efforts to gain legislative support and the informed cooperation of the public to control or abate these sources of pollution. We are equally concerned with these problems today, but our major concern stems from hazardous and toxic wastes which threaten our groundwater supplies and the quality of our air. Our ability to create products with the potential for harm to human health and environmental quality, so far, outstrips our ability to handle and dispose of these products safely. This complex problem must be solved in the coming decades before degradation of the environment is so profound that it will haunt our children for generations to come.

Many of the challenges of yesterday have been tackled with a mixture of timely legislation, appropriate regulation, strong health and environmental education, advances in technology, and most importantly, by dedication and hard work of the staff of the department. Yet today the department, the state, and the nation are faced with a new set of challenging health and environmental problems, and even some recurring problems from the past. Only through foresight, planning, and an articulation of unified policy goals will the department be able to take the proactive measures required to meet the challenges of today and the demands of tomorrow.

Chronology of the State Board of Health

March 7, 1885 — The Kansas Legislature established the state board of health and local boards of health. Dr. J. W. Redden was named the first secretary and Dr. Johnson was elected president of the board.

October 1, 1885 — Vaccination for smallpox was required of all children attending public schools in the state.

April 1, 1886 — The office of the state board of health was moved to the state house.

1898 — Dr. Samuel J. Crumbine from Dodge City became a member of the board.

1900 — An Embalmers Examining Committee was started to prove fitness to prepare dead bodies after death from a communicable disease.

1901 — A quarantine law was passed permitting the quarantine of smallpox, diphtheria, scarlet fever, and other infectious diseases.

1901 — The State Board of Medical Registration and Examination was established.

1901 — The first law was passed defining food and drug adulteration.

1903 — The first woman, a bacteriologist, was named to the board.

December, 1903 — The board passed a resolution calling for teachers to examine the eyes and ears of all school children at least once a year.

June 2, 1904 — Dr. Samuel Crumbine was named executive secretary of the board.

1904 — Dr. Crumbine urged legislation that would place municipal water supplies and sewerage systems under the jurisdiction of some responsible department of state government because the number of reported diphtheria cases had reached 1000 with 300 deaths.

1905 — The food and drug law was amended and strengthened.

1905 — The first Bulletin of the State Board of Health was published as the "main cog" in the board's health education program.

Sept. 1, 1905 — Dr. Crumbine collected the first samples of food to be tested for adulteration.

July, 1906 — Dr. Crumbine launched his "Swat the Fly" campaign.

December, 1906 — The board began its first study of the ravages of tuberculosis.

March 7, 1907 — The Food and Drug Law was adopted and four inspectors were hired to enforce the law, collect samples, and make sanitary inspections.

March, 1907 — Water and sewage bills were passed by the legislature and field sanitation work was started.

March 31, 1907 — The Kansas Legislature banned the common drinking cup.

July 1, 1907 — Dr. Crumbine became the first full-time executive secretary of the board.

1907 — A law was passed requiring physicians to report tuberculosis cases within 24 hours of diagnosis.

1907 — Amendments to the water and sewage law gave the State Board of Health jurisdiction over operation of all water plants and sewage systems in the state regardless of their time of construction and authorized investigation of stream pollution by industrial wastes.

1907 — Kansas passed the first laws any place in the world regulating the sanitation of oysters.

1907 — Dr. Crumbine launched his "Don't Spit on the Sidewalk" campaign.

Dec. 1908 — The Kansas Society for the Study and Prevention of Tuberculosis was created following a meeting called by Dr. Crumbine and Governor E. W. Hoch and held in the House chambers.

1908 — More than 4,000 cases of smallpox were reported in the state.

1908 — The legislature appropriated $20,000 to carry on a state-wide educational campaign against tuberculosis.

1909 — The first divisions were created within the board — the division of food and drugs and the division of sanitation.

1910 — Distribution of free diphtheria antitoxin for treatment of indigent persons was started.

1911 — Dr. Crumbine was elected Dean of the School of Medicine at the University of Kansas in addition to being executive secretary of the state board of health and started a new course called "sanitary engineering" which resulted in the first union in the country of curative and preventive forces in the field of public health.

Sept. 1, 1911 — The common roller towel was prohibited in public places and private schools.

1911 — A law requiring the registration of all births and deaths was passed.

1911 — A plan was developed for remedial action to abate the heavy pollution of the Neosho and Verdigris Rivers.

1912 — Funds were requested for research on the matter of treating industrial wastes.

1913 — The first state epidemiologist was hired.

1913 — The first study of the pollution of the Missouri River was carried out as a result of a request made by Dr. Crumbine two years earlier.

1913 — The Hotel and Restaurant Commission, separate from the State Board of Health, was established.

1914 — Free distribution of prophylactic solution for eyes of the newborn was authorized.

1914 — Free distribution of smallpox vaccine was started.

1915 — Dr. Crumbine established educational programs for public health workers in Kansas.

1915 — The division of child hygiene was established.

1916 — The first school nurse was hired in Dodge City.

1916 — 263 Kansans died from typhoid fever.

1917 — The railroad car, Warren, was equipped with health education exhibits and sent on tour of the state.

Sept. 1917 — A Tri-state Sanitary District was organized, including the southeast corner of Kansas, the southwest corner of Missouri and the northeast corner of Oklahoma, primarily to combat tuberculosis. Dr. Thomas Parran, Jr. was assigned by the U.S. Public Health Service as the first administrator of the district.

1919 — The first full-time county health officers were appointed in Geary, Marion, and Cherokee Counties.

1920 — The Public Health Laboratory was established.

1922 — The Division of Public Health Nursing was established.

1923 — Dr. Crumbine resigned as Executive Secretary of the Board.

1927 — The first federal funds became available for public health nursing.

1927 — Sanitary inspections of schools were started.

1927 — The infant mortality rate was 54.1 deaths/1000 births.

1929 — There were 130 public health nurses employed in the state.

1929 — A bill to permit tax levy for county health work was passed.

1932 — $19,500 was appropriated for emergency drought relief.

1938 — There were seven divisions within the board: sanitation, child hygiene, food and drugs, dental hygiene, public health laboratory, vital statistics, and preventable diseases (including tuberculosis, venereal disease and epidemiology).

1939 — The division of preventable diseases was separated into three separate divisions: tuberculosis, venereal disease, and epidemiology.

1939 — The Hotel and Restaurant Board was established.

1939 — A state-wide program for constructing sanitary toilets was started. More than 46,500 were constructed.

1940 — The divisions of health education and local health services were established.

1943 — The division of public health nursing was re-established.

1943 — The Emergency Maternity and Infant Care Program was started to provide maternity care for wives and medical care for infants of enlisted men in the four lowest pay grades of the armed forces.

1943 — A division of industrial hygiene was established.

(Continued on page 204)

Infant Survival: 1915-1985 & Beyond

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"The life duration of babies is the most delicate test of health conditions."

—Florence Nightingale, 1893

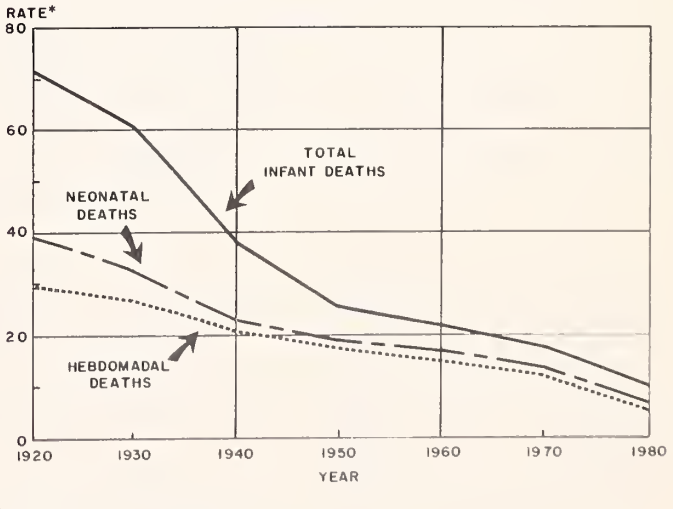
SINCE THE turn of the century, there has been growing recognition that the survival of infants is the best measurement of the health of a community, a state, and a nation. The Surgeon General of the United States, in the 1980 report on health promotion and disease prevention, set a goal for the nation of reducing the infant mortality rate to fewer than nine deaths for every 1,000 live births by 1990.[1] This goal appears to be achievable in Kansas as the provisional rate for 1984 is 9.8/1,000 live births, the first time the rate has been less than 10.1.

For Kansas, 1985 culminates a seven-decade effort to reduce infant mortality and morbidity. A system for maintaining vital records of births and deaths was established in 1912 by the Kansas Board of Health under the direction of Dr. Samuel J. Crumbine, Executive Secretary of the Board, as well as Dean of the University of Kansas Medical School. In 1913 it became apparent that one of every 11 live born infants died during their first year. This year the Kansas Board of Health issued a special bulletin devoted to "The Care of Infants" with the subtitle, "The Food and Care of the Child Determines the Future of the Citizen, and the Physical Strength of the Potential Fathers and Mothers of the State."[2] This publication encouraged a pregnant woman to consult her physician as soon as she "becomes expectant," to have reasonable exercise, nourishing food, abundant sleep (preferably ten hours a night), scrupulous cleanliness, fresh air, avoidance of excitement, and to take care of her breasts to keep them "soft and healthy" so as to nourish her infant.

The 1915 Legislature established a Division of Child Hygiene in the Board of Health with its general duties to include "the issuance of educational literature on the care of the baby and the hygiene of the child, the study of the causes of infant mortality and the application of preventive measures for the prevention and the suppression of the diseases of infancy and early childhood."[3] This original mandate has guided the state's maternal and child health programs through the years, with their effectiveness measured by the reduction of infant mortality from 71.7/1,000 live births in 1920 to 10.1/1,000 in 1980 *(Figure 1)*. These rates translate to 2,899 infant deaths in 1920 decreasing to 412 in 1980.

During the six decades (1920-1980), the neonatal mortality rate decreased by 83% and the post-natal by 89% *(Table I)*. It is well accepted that most of the decline, until 1940, was the result of safe food and water, sanitary sewage disposal, improved nutrition, rising income, improved housing, and better education.[4] The decline between 1940 and 1950 can be traced to improved obstetrical care and medical treatment of pneumonia and other infectious diseases with sulfa drugs and penicillin. The 52% reduction in the neonatal rates in the 1970s is a tribute to improved medical care of high risk mothers and newborns through perinatal care systems. During the same period dramatic age/parity shifts were observed with decreasing proportions of births to high risk women.[5]

The transition from home to hospital deliveries through the decades may also have influenced infant



*Rate per 1,000 live births

Figure 1. Infant mortality rates by component — Kansas, 1920-1980.

* MCH Programs
† Director, Division of Health
From the Kansas Department of Health & Environment
Address reprint requests to Dr. Schloesser, Kansas Dept. of Health & Environment, Forbes Field, Bldg. 740, Topeka KS 66620.

TABLE I
COMPARISON OF NEONATAL AND POSTNEONATAL MORTALITY RATES
KANSAS 1920-1983

	Neonatal Mortality		Post-Neonatal Mortality		Neonatal/ Postneonatal Ratio
	Rate*	% Change	Rate*	% Change	
1920	39.3	—	32.9	—	1.2
1930	32.7	−17	19.3	−40	1.7
1940	23.1	−29	15.0	−22	1.6
1950	19.4	−21	6.3	−58	3.0
1960	16.9	−13	5.4	−14	3.0
1970	13.7	−19	4.0	−26	3.6
1980	6.6	−52	3.5	−12	1.9
1983	5.9	−10	4.2	+17	1.7

* Deaths/1000 live births

survival *(Table II)*. This shift was greatest during the 1940s. Maternal survival was influenced even more directly than infant survival by this change. In 1983, only 185 of the state's 40,365 live births (0.5%) occurred outside a hospital setting.

A profile of public health efforts to reduce infant mortality in Kansas 1915 to present includes the following:[6]

- 1915: Establishment of a Division of Child Hygiene to study causes of infant deaths and apply preventive measures
- 1919: Statute requiring the licensing of all child care and maternity facilities because a high number of infants died in orphanages
- 1920: Development of sanitation measures
- 1923: Issuance of a Mother's Manual to encourage health care during pregnancy
- 1920-1970: Immunization programs as vaccines became available — diphtheria in 1920s; pertussis 1930s; polio 1950s; rubeola and rubella 1960s
- 1935: Establishment of a film library and a literature distribution service at the Kansas Board of Health
- 1941-1945: Administration of the Emergency Maternity and Infant Care Program (EMIC) for war wives
- 1943: Prenatal and premarital screening laws for syphilis

TABLE II
OUT OF HOSPITAL DELIVERIES, MATERNAL DEATHS AND NEONATAL DEATHS
KANSAS 1920-1983

	Live Births	Out of Hospital Deliveries %	Maternal Deaths Number	Maternal Deaths Rate*	Neonatal Deaths Number	Neonatal Deaths Rate†
1920	40,386	88	258	63.9	1,586	39.3
1930	33,974	76	235	69.2	1,111	32.7
1940	28,695	48	102	35.5	662	23.1
1950	43,911	7	27	6.1	852	19.4
1960	50,782	1	9	1.8	857	16.9
1970	38,215	.5	5	1.3	524	13.7
1980	40,686	.5	4	1.0	269	6.6
1983	40,365	.5	4	1.0	237	5.9

* Deaths/10,000 live births
† Deaths/1,000 live births

KMS

Kansas Medical Society Newsletter

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MALPRACTICE BILL TO AFFECT PREMIUMS

Malpractice premiums continue to rise. Almost without exception, physicians in every state will absorb sizable increases again this year. There is some encouraging news, however, because of a bill enacted by the Kansas Legislature.

As a result of Substitute for SB 110 (the KMS sponsored malpractice bill) premium increases scheduled to take effect July 1 will be somewhat lower than originally planned. The premium surcharge which goes into the Health Care Stabilization Fund was to increase from 80% to 120%, but that figure has been lowered to 110%. Additionally, the St. Paul Insurance Company has announced that their premiums will increase 23% this year, instead of the scheduled 27%. Other insurers are considering more modest increases also.

Although these numbers aren't cause for great celebration, they nevertheless indicate that the elimination of the collateral source rule (a key part of the malpractice bill) will lower awards. If the effect on awards is significant during the first year, it is likely that even greater reductions will follow. The bottom line this year is that for many physicians, malpractice premiums will be several hundred to as much as a couple thousand dollars less than they would have been if Substitute for SB 110 had not passed.

KMS is working on recommendations for further changes to present to the legislative interim study committee, which will begin work this summer. Professional liability reform remains the number one priority for KMS, as every avenue must be explored for resolving the crushing burden of rising premiums and a system that is out of control. Watch your mail for details of KMS plans for the coming months.

PUBLIC AFFAIRS DIRECTOR NAMED

Marsha J. Hutchison has joined the KMS staff as the Director of Public Affairs. Her responsibilities include public relations, KaMPAC, and assisting Jerry Slaughter, Executive Director, with lobbying activities. Marsha's background is in public relations and governmental affairs, with several years of experience working with the Kansas Legislature.

CONTROLLED SUBSTANCE DIVERSION

Despite increasing comprehensive legislation, strict law enforcement, more stringent and innovative drug control systems and public education, the illegal sale, use, and abuse of controlled substances continues. It has been found that health care professionals (including physicians, pharmacists, and nurses) are implicated in the diversion of substantial amounts of a variety of controlled substances from hospitals. Data from several studies indicate that .5 million or more dosage units per year may disappear from U.S. hospitals. Of incidents reported in two of the studies, 37-38% were documented and 62-63% were suspected. Slightly less than half of the incidents involved Schedule II drug products.

It was found that registered nurses were involved in nearly 70% of all reported incidents; pharmacists and pharmacy technicians were responsible for 8-13%; and physicians for 3%. However, the total number of dosage units stolen by pharmacists and pharmacy technicians exceeded those taken by nurses.

Nurses most often diverted the opiate drugs, and these diversions accounted for nearly 3/4 of all Schedule II diversion incidents. Hospital pharmacists and pharmacy technicians most frequently diverted the stimulant drugs such as cocaine and amphetamines.

The two most frequently diverted drugs are meperidine and diazepam which together accounted for almost one-half of all controlled substance diversion reports from hospitals.

KaMPAC TAX CREDITS

You may now claim a tax credit for your personal contributions to the Kansas Medical Political Action Committee. Tax credits may be claimed for contributions by personal check as follows: up to $50.00 credit for those filing a single return; up to $100.00 credit for those filing a joint return.

JANUARY KANSAS MEDICINE

The KANSAS MEDICINE staff underestimated the demand for the first issue in the new format. Our supply of the January 1985 issue is totally depleted, and we are still receiving requests for copies. If you have a copy you no longer wish to keep, will you please send it to the KMS office for recycling?

UNIFIED MEMBERSHIP

The 1985 House of Delegates adopted Resolution #85-12 that implements unified county-state-national membership effective January 1, 1986. For additional information about this resolution and its implementation, be sure to read the AMA Delegate Report on page 169 of this issue of KANSAS MEDICINE.

SELECTION UNDER MEDICAID

The fact that a physician, or other provider of services to Medicaid recipients, certifies to provide such services in compliance with the nondiscrimination provisions of the laws (Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973) does not obligate the physician to accept all Medicaid patients. According to the legal opinion of Wayne Stratton, KMS Legal Counsel, the laws speak to discrimination on specified grounds - those being race, color, national origin or handicap. Neither law automatically converts Medicaid patients into some type of special, protected class. Therefore, the physician has the right to decide whether to accept, or not accept, as a patient an individual in the Medicaid program by employing the same criteria used for patients generally: in non-emergency situations and if a physician-patient relationship had not been previously established.

PROs MONITORING PROJECT

The AMA is asking physicians and hospitals to report their experiences with the peer review organizations (PROs) established to monitor the health care delivered to Medicare beneficiaries. While the AMA is interested in all experiences physicians and hospitals can attribute to the new peer review system, it is particularly interested in changes in length of stay, admission and discharge policies, preadmission certification procedures, utilization and quality review results. In addition, the AMA is seeking reports on relevant administrative relations between hospitals and physicians and the PROs, any demonstrable impact that PRO review may have on the cost or quality of care and the results of any PRO efforts to review patients other than Medicare beneficiaries. The AMA asks physicians and hospitals to write c/o AMA PRO Monitoring Project, Department of Health Care Financing and Organization, P.O. Box 10947, Chicago, 60610. All sources will be kept confidential.

MEDICAL RECORDS

Under the law, is a physician always required to provide a patient with access to his or her medical records? Generally, yes. Upon written request, a physician must provide a patient with one of the following: a copy of the patient's health record, the portion of the patient's health record relating to a specific condition or a summary of the record. The form on which the information is provided is at the option of the physician. In addition, a reasonable charge may be assessed the patient to cover the cost of providing this information.

PATIENT'S CHOICE

Some 39% of Americans have decided at some time in their life that their doctor did not have a cure for what ailed them and prescribed a pink slip for him. The Harris poll quotes, "Americans and their doctors" found that patients most frequently changed physicians because the doctor "didn't have a friendly personality," "didn't answer questions honestly," or "wasn't competent," or because the "treatment didn't work." Results of this poll were reported in the May issue of American Health.

KMS HOUSE OF DELEGATES

A complete report of the proceedings and actions of the May annual meeting held in Colorado Springs will appear in the July issue of KANSAS MEDICINE.

HCFA: DO NOT WAIVE MEDICARE CO-INSURANCE

The Health Care Financing Administration (HCFA) has directed Medicare fiscal intermediaries (Blue Cross in Kansas) to take corrective action against physicians who routinely waive Medicare deductibles and co-insurance. HCFA told them to "aggressively seek out instances of routine waiver and to make specific reductions in charge screens for these providers."

Failure of physicians to make efforts to collect deductibles and co-insurance is a violation of Medicare law because it lowers the physician's actual charge. Medicare is responsible for reimbursing only 80% of this actual charge. If the physician waives the co-insurance and still bills the full charge and collects 80% from Medicare, he/she may be subject to a $2,000 fine per occurrence and can be barred from the program for repeated violations. Individual physicians who on occasion waive deductibles where financial circumstances warrant it are not the target of this HCFA directive. Being sought out are those individual physicians, groups or suppliers who "routinely and consistently" waive collection of deductibles and co-insurance. Carriers are specifically asked to review advertising for any statements indicating that waivers would be made.

SAVE ON MAGAZINES

You can subscribe to some of the best "waiting room" publications at reduced rates through the new KMS magazine program. See pages 202-203 in this issue of KANSAS MEDICINE.

- 1947: Hospital licensing law which authorized regulations for maternity and newborn units
- 1955-1963: Development of standards for maternity care and care of the newborn in cooperation with the Kansas Medical Society and published in *The Journal of the Kansas Medical Society*[7]
- 1959: Revision of the Kansas birth certificate to include a medical supplement which linked birth/death certificates for annual comparative hospital perinatal casualty studies
- 1965: Kansas newborn screening law
- 1965: Kansas Family Planning Law which required the Board of Health to establish family planning clinics throughout the state
- 1967: Impetus to develop local health departments from 20 to 100 counties by 1985
- 1969: Legalization of medical terminations of pregnancy
- 1974: Establishment of the WIC Program (Supplemental food program for women, infants and children)
- 1974: Establishment of a Statewide Perinatal Network with Level III and Level II centers and guidelines for Level I and Level II centers published in *The Journal of the Kansas Medical Society*[5]
- 1975: Development of Maternity and Infant Care Projects for adolescents using teams of professionals working closely with private physicians and hospitals
- 1977: Kansas Crippled Children's Programs transferred to the Kansas Department of Health and Environment and expanded services to additional handicapped infants
- 1977: Healthy Start/Home Visitor program using lay visitors to visit families with newborns and high risk pregnant women
- 1982: Black Infant Mortality Reduction Projects initiated in Wyandotte, Sedgwick, Shawnee, and Geary counties
- 1983-1984: Maternal and Child Health Jobs Bill funds were targeted to 43 counties to strengthen public health services for high risk pregnant women and young children
- 1984: Initiation of a project for the Preservation of Black Families in the Kansas City area
- 1985: Expansion of the Healthy Start program to include pregnancy outreach in 35 counties.

These combined efforts all contributed to improved infant survival. During the years 1979-1983, infant mortality rates leveled off between ten and eleven. Kansas analyses of infant deaths reveal that infants who weigh less than 2500 grams (6.1% of births) account for 74% of neonatal deaths. Infants who weighed less than 1500 grams (1% of live births), were responsible for 61% of neonatal deaths. The relationship between low birth weight and infant loss is well known.[9] According to the Institute of Medicine's 1985 study on low birth weight, babies under 2500 grams are 40 times more likely to die in their first week of life and make up two-thirds of all newborns who die. Those who survive are more likely to have various problems including neurodevelopmental handicaps. Obviously the relative proportion of low birth weight infants will in large part determine the infant mortality rate within the state.

Between 1965 and 1983, the low-birth-weight rate declined in Kansas by 15%, from 7.2% to 6.1%. Although the decrease is modest, the first-week survival rates of low birth weight infants, particularly those under 1500 grams, increased dramatically *(Figure 2)*. The Surgeon General's goal of a 5% low-birth-weight rate by 1990 will require a much greater reduction in Kansas than has occurred during the past two decades *(Figure 3)*. To accomplish this, proven preventive health programs must be applied universally to all pregnant women.

Sociodemographic changes such as fertility rates, family size, and the relative number of births to adolescents and minority populations also impact on pregnancy outcome and infant survival. There appears to be a temporal relationship between high fertility and high infant mortality rates in a number of Kansas communities. While attending to improving the care of pregnant women, one must not lose

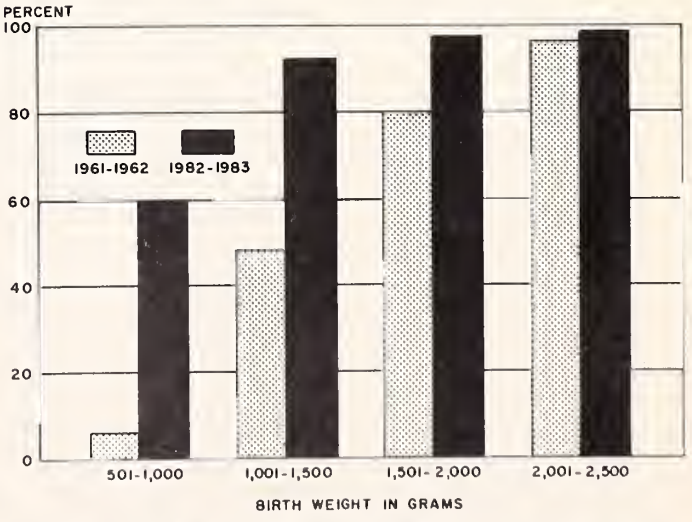


Figure 2. Percent of low birth weight infants surviving the first week of life by birth weight — Kansas, 1960-1961 and 1982-1983.

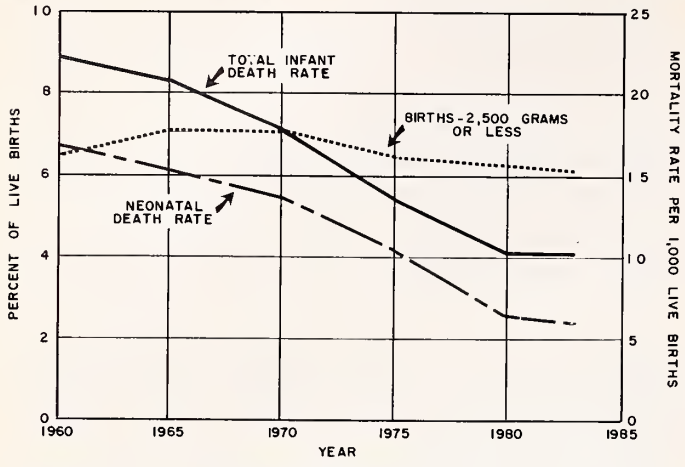


Figure 3. Low birthweight birth and infant death rate trends in Kansas, 1960-1983.

sight of the importance of timing and spacing of pregnancies for an improved pregnancy outcome. There has been a decrease in families with four or more births from 13.2% in 1975 to 9.3% in 1983.

Infants born to adolescents have a high incidence of low birth weight, although these rates have declined since 1975 *(Table III)*. Even more impressive is the decreased proportion of births to adolescents, a major factor in the state's decrease of infant mortality. Nearly one-half of the births to adolescents were to unwed mothers. For black adolescents, the infant mortality rate in 1983 was 20.7 compared to 13.8 for white.

Although infant mortality has decreased for white and black during the past 20 years, the black rate has remained about twice as high as for white. The low-birth-weight-rate in 1983 was 12.6% for black and 5.5% for white. Births to black women under 18 years old (10.1% of black births) had a low-birth-weight rate of 15.3%. Births to white women under 18 years old (3.4% of white births) had a low-birth-weight rate of 8.6%. This combination of factors in large part explains the wide differential in pregnancy outcome between races.

Adequacy of prenatal care has been assessed by KDHE each year since 1979, using an index that couples onset of care and number of visits with gestational age of the fetus.[10] The adequacy of care has increased from 80.2% in 1979 to 84.7% in 1983. Only 70% of adolescents receive adequate care. According to a Michigan study, adequate prenatal care was associated with an increase in birth weight.[11] Since differences in birth weight account for the major differences in infant mortality between races, the fact that prenatal care can improve birth weight has important policy implications. A Kansas study showed that a woman without adequate prenatal care had twice the risk of her infant being born of low birth weight and twice the risk of infant death as the infant born to a mother with adequate care. If the 6,000 women studied had received adequate care, 400 low birth weight births and 65 infant deaths might have been averted.

The Kansas Maternity and Infant Care program (M and I) is an intervention model which addresses these risk factors and shows promise in reducing infant mortality and low birth weight. Currently there are 11 projects conducted by local health departments in cooperation with private physicians, hospitals, and social agencies. The program targets pregnant adolescents and their infants to one year of

(Continued on page 198)

TABLE III
LOW BIRTH WEIGHT RATES FOR WOMEN BY AGE GROUP
KANSAS, 1975-1983

	Live Births		*Low Birth Weight*	
1975	*Number*	*% of Total*	*Number*	*Rate*
>20	27,247	80.8	1,566	5.74
<20	6,460	19.2	620	9.6
<18	1,566	5.74	253	10.4
1983				
>20	35,350	87.6	2,040	5.77
<20	5,015	12.4*	418	8.3†
<18	1,600	4	158	9.9

Note: Births to women under 20 years
* 35% decrease in percent of live births
† 13% decrease in low birthweight rate

Kansas Public Health Labs — 1886-1985

ROGER H. CARLSON, Ph.D.,* *Topeka*

Historical Perspectives

In the year following the legislative establishment of the Kansas Board of Health in 1885, a microscope was purchased to begin laboratory services in support of public health in Kansas. Early laboratory work was performed on a part-time basis by a number of local physicians, chemists, and veterinarians until the first full-time bacteriologist was employed in 1905. Infectious diseases such as cholera, typhoid fever, tuberculosis, diphtheria, and childbed fever were significant public health issues on the Kansas frontier. The state health laboratory examined specimens microscopically and began to isolate and identify etiologic disease agents as Robert Koch and Louis Pasteur pushed the science of bacteriology into the 20th century.

On a parallel course, in 1915 the sanitary engineering laboratory of the Division of Environment was established to provide the laboratory with data necessary to monitor the quality of air, milk, and waterborne vectors of disease. While the low population and light industrialization of Kansas resulted in fewer immediate environmental health problems when compared with many eastern states, early emphasis on prevention and the development of intervention strategies soon became characteristic of Kansas public health programs. This legacy was established by Dr. Samuel J. Crumbine who served as Secretary of the Kansas Board of Health and Dean of the University of Kansas School of Medicine during the formative years of the agency.

In the years following World War II, active immunization and the development of antibiotic therapy contributed to the decline of many infectious diseases as the primary cause of death in Kansas. Health laboratories implemented serological tests for syphilis and a variety of viral diseases. Cell culture for the isolation of viruses followed the development of this technology in the late 50s and early 60s. The Topeka tornado of 1966 destroyed the health laboratories which were subsequently moved from the National Reserve Building in Topeka to temporary quarters at 4000 East Tenth Street. The Kansas laboratories pioneered the use of breathalyzer tests for court trial of the alcohol impaired driver and proved the comparability of blood and breath analyses. Chemical toxicology tests were performed to assist county coroners and pathologists in determining the cause of unattended deaths.

Environmental chemistry laboratories underwent a major technical revolution in the post-war years as the warnings of Rachel Carson and other environmentalists raised the consciousness of public health laboratorians and the general public alike regarding the long term threat of chemical contamination in the environment. Simple colorimetric tests gave way to sophisticated analytical instrumentation and computer systems which today identify and quantitate trace toxic chemicals at the part-per-billion and part-per-trillion levels.

Increasing awareness of the close and important interrelationships between health and environmental priorities for the protection of Kansas citizens led to the legislative organization of the Department of Health and Environment in 1974. The Forbes Field Base hospital was procured for laboratory use at this time, and health and environmental laboratories were consolidated into a single modern facility. The remainder of the agency is located around the central laboratory which currently occupies 79,539 square feet on four floors of this building.

The Current Laboratory

In the last decade, the state public health laboratory has matured into a state-of-the-art facility which annually examines more than .25 million samples and specimens to produce 750,000 specialized analyses each year. A staff of 71 chemists, microbiologists, and support personnel and an annual budget of $2.5 million enable this laboratory to provide timely and accurate technical data in support of public health issues in our state.

Microbiology Laboratories. Current microbiology laboratories include health microbiology, virology/serology, and environmental microbiology units. Each laboratory contributes specialized analytical services for disease prevention and control. Health Microbiology reference laboratories assist hospitals and clinical laboratories throughout the state with

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KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
LABORATORY SERVICES AND RESEARCH
YEARLY REPORT FY84

HEALTH LABORATORY SPECIMENS RECEIVED AND TESTED
July 1, 1983-June 30, 1984

Chemistry			
Toxicology	507	T.B. Isolates	4,719
Forensic Samples	460	Mycology	1,042
Alcohol	2,553	Enterics Organism	5,274
T4	32,330	Parasites	8,970
Total	35,850	Pinworm	339
Virology and Serology		Malaria	26
Viral Culture	1,839	Arthropods & Misc.	2
Viral Serology	7,898	Beta Strep	2,764
Chlamydia	1,417	Food Bacteriology	105
Mycoplasma	416	Misc. Bact. Isolates	7
Rickettsia	211	Misc. Bact. Reference	277
Fungus Serology	609	Culture Ident. Iso.	531
Syphilis Serology	39,002	Culture Ident. Ref.	898
Febrile Agg.	73	PKU	32,273
Legionnaires	290	F.A. Bordetella pertussis	633
Total	51,755	Total	90,425
Microbiology		*Records and Reports*	
G.C.	31,963	Specimen Containers Sent	145,527
Staph Culture	332	CDC Specimens Referred	269
T.B. Reference	270	Total	145,796

difficult identification and confirmation of bacterial pathogens. Thirty thousand gonorrhea cultures are examined each year. Each gonorrhea culture is preincubated at the collection site before being mailed in a container pouch with a carbon dioxide release tablet to maintain viability in transit. Food microbiology laboratories isolate, identify, and characterize causative organisms as well as staphylococcus enterotoxins involved in foodborne illness. Tuberculosis and mycology laboratories isolate and confirm pathogenic species at the request of health care providers. Parasitology laboratories identify intestinal parasites in 10,000 specimens each year as giardiasis has become a significant problem in child day care centers. Tropical parasites are frequently encountered in Cuban and Chinese refugee populations. Enteric microbiology laboratories examine more than 5,000 specimens each year for Salmonella, Shigella, and Campylobacter pathogens. Throat culture screens for Group A beta-hemolytic streptococci which were performed in the 1960s and early 70s were dropped as improvements in antibiotic therapy decreased the incidence of the long-term sequella diseases of streptococcal infections.

Environmental microbiology laboratories monitor the 1400 public drinking water supplies in Kansas as well as streams, reservoirs, and private wells. Coliform indicators of fecal pollution are detected through membrane filter procedures. Each of the 45,000 samples which are examined each year must arrive in the laboratory within 30 hours after collection. This work is performed in compliance with the federal Safe Drinking Water Act.

Virology and serology laboratories isolate viral pathogens using a variety of animal and cell culture techniques. Mandatory premarital syphilis serologies were abandoned when it became clear that a more targeted program for high risk populations would provide a more effective approach to the control of this disease. Modern enzyme-linked immunosorbant assays have improved the speed and accuracy of information available to physicians. Detection of IgM antibodies during the early phase of rocky mountain spotted fever and detection of antibodies to the HTLV-III virus associated with acquired immune deficiency syndrome (AIDS) are representative of current test services.

Chemistry Laboratories. Thirty-two thousand Kansas newborns are screened for phenylketonuria, hypothyroidism, and galactosemia each year by the Health Chemistry laboratories. Positive screening tests are referred for diagnosis and supportive therapy. Detection within the first weeks of life has

(Continued on page 205)

Geriatrics: The New Challenge

MARY C. CORRIGAN, M.A.*; RICHARD J. MORRISSEY, B.A.† *and*
JOSEPH G. HOLLOWELL, JR., M.D.‡, *Topeka*

Concerns about health care for the elderly are relatively recent in origin. When public health was "born" in Kansas 100 years ago, less than 3% of the population was age 65 years or older[1]; life expectancy at birth was only 47 years.[2] Morbidity and mortality due to acute and infectious diseases were the major health concerns. By establishing water, food quality and sanitation controls, public health programs saved many lives enabling more people to live to age 65 years. Subsequent advancements in medical knowledge and technology further improved the population's health status.

Today, more than 13% of the Kansas population is age 65 years or older, and life expectancy exceeds 74 years.[3, 4] By the early 21st century, more than 18% of the population will be 65 years or older and life expectancy will approach 85 years[2, 3] *(Figure 1)*. Within the aged population the number of "old-old" — those 85 and over — will double by the year 2000.[5] In the absence of disease or other health problems, organ system declines do not begin to cause problems until the eighth decade of life.[2]

Current Care

Increased longevity has resulted in a new set of health concerns. Chronic and degenerative health disorders are now the major causes of morbidity and mortality. Often these health problems result from life-style decisions related to smoking, diet, and exercise. Health promotion programs that encourage positive life-style habits are gaining prominence in the public and private sectors. The benefit gained should be a healthier future generation of older people.

The image of care for the aged today is one of institutional/nursing home care because of the emphasis on dealing with chronic and degenerative disorders. Reimbursement provided through Medicaid, and Medicare to a lesser degree, correlate with the doubling of nursing home beds in the last two decades.[6] The public health role has been to assure maintenance of quality standards in the institutional setting. A minority of the elderly, however, reside in nursing homes: 7% in Kansas and 5% nationwide.[3]

Growth in the types and locations of medical services available, advancements in medical technology, population growth, and inflation have resulted in increasing expenditures for health care. The cost of health care for the elderly is high, more than $120 billion in 1984, or $4,202 per person.[7] Government programs cover two-thirds of the expenditures, predominantly for institutional and physician services. Consideration of expenditures alone may be misleading however. Under Medicare, for example, 9% of elderly beneficiaries use 70% of reimbursable services, while 39% never file a claim.

To contain costs, Medicare established prospective payment systems for hospitals and froze physician fees. Medicaid implemented a system to screen potential nursing home users and arrange for "alternative" services when appropriate. These programs and others being explored ignore two key issues. First, the increasing number and proportion of elderly make it unlikely that future expenditures for health care can be substantially reduced. Second, the older person often needs services beyond those that the medical system currently provides.

Future Health Care

Health care for the elderly should be based in a coordinated system or continuum of long-term care. Long-term care is an umbrella term used to describe a range of medical/health, psychological, social, and general support services which will help maintain or enhance functional abilities. Emphasis is not on "cure" *per se* because many chronic problems cannot be cured. Rather, attention must be given to daily activity abilities and to the care necessary to maintain life-styles that are as independent and normal as possible. To accomplish this requires an understanding of who the elderly are and the needs they have.

Gerontologist Stanley Brody has proposed a system that views older people in terms of "well" and "frail" health states.[9] In that system the largest

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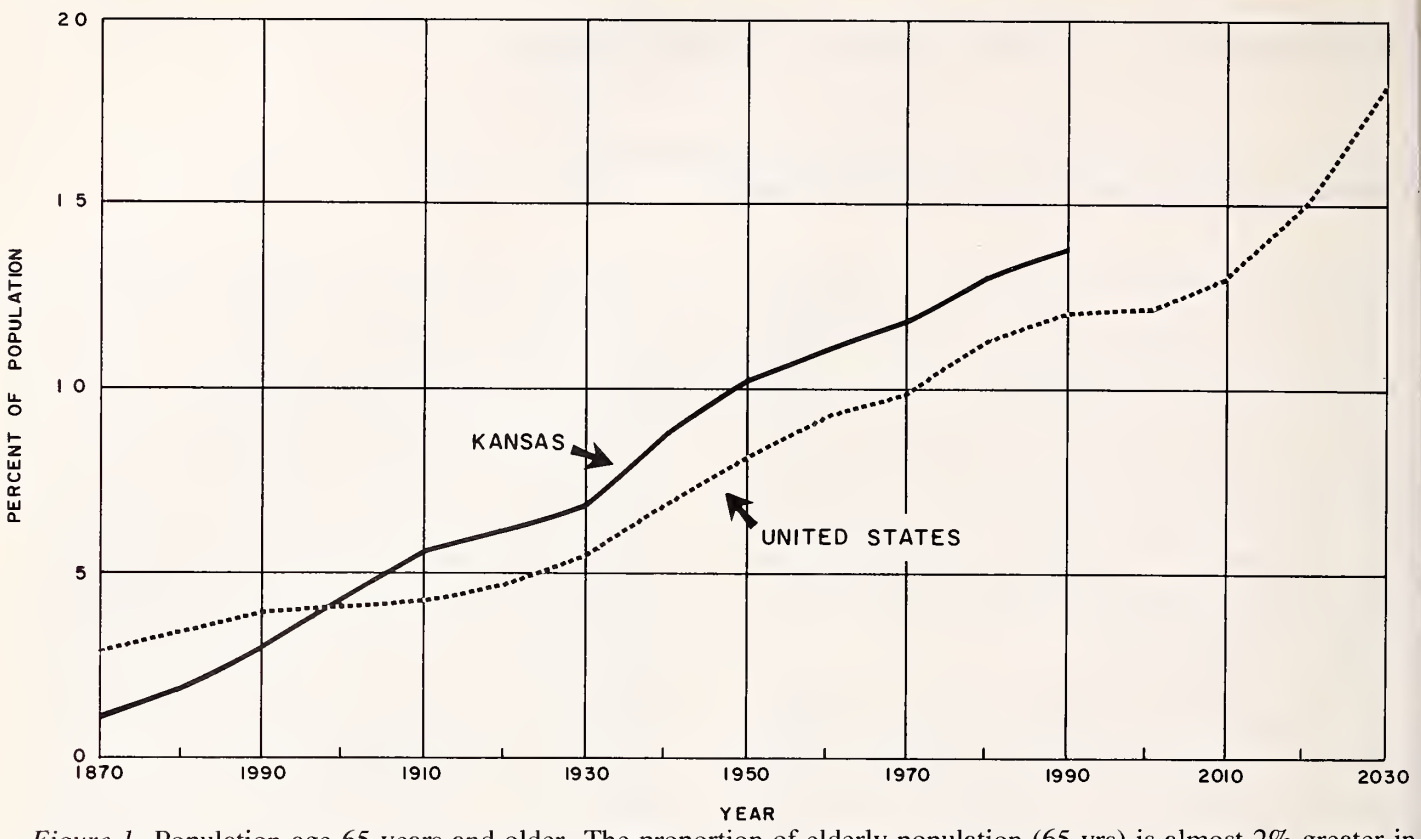


Figure 1. Population age 65 years and older. The proportion of elderly population (65 yrs) is almost 2% greater in Kansas than the U. S. as a whole. A rapid increase in the proportion of elderly is projected after the year 2000, with the most rapid increase among those 85 years and older.

segment of the older population is comprised of "well elders," elders being a neutral term for referring to the older population. Self reports of health status correlate with physician findings and indicate that 80% of elders are in good to excellent health; however, well elders are not without problems. Four of five have at least one chronic health problem, and one in six report functional problems.[10] Maintaining the well state can require physician services and screening clinics, as well as health promotion, and social activities to prevent isolation and depression.

"Transient frail elders" require short-term, active treatment and rehabilitation,[9] often during a post-hospitalization period of 90 days or less. The 18%+ of elders hospitalized each year are most likely to need rehabilitation in skilled nursing facilities, outpatient clinics, or day care settings. At home they may require nutrition support, homemaker aid, and other services. Appropriate services over the short term should allow this group to achieve well status.

"Permanently frail elders" on the other hand have long-term service needs due to progressively degenerative disorders;[9] *e.g.,* Alzheimer's Disease and chronic obstructive pulmonary disease. Some permanently frail elders will require intermediate level nursing home care. Care in the home setting is preferable, if possible, but may require family support services such as home health, respite care, day care, and electronic medical alarts to name but a few.

A Model for Care

A model for elder care or long-term care in Kansas *(Figure 2)* encompasses key elements from the preceeding discussion: recognition of the basic needs of all elders, provision of a range of services in a variety of sites, and involvement of medical and nonmedical service providers.

The multidisciplinary health team at the community level is the key component of the model. The health team assesses the physical/medical, social, mental and environmental status of an elder, recommends care, and plans intervention and prevention strategies.[11] Demonstration programs in Kansas and the U. S. generally have relied on nurses and social workers to identify individual needs using established assessment tools, and have used case managers to link elders with services. Community physicians have had little, if any, involvement with the

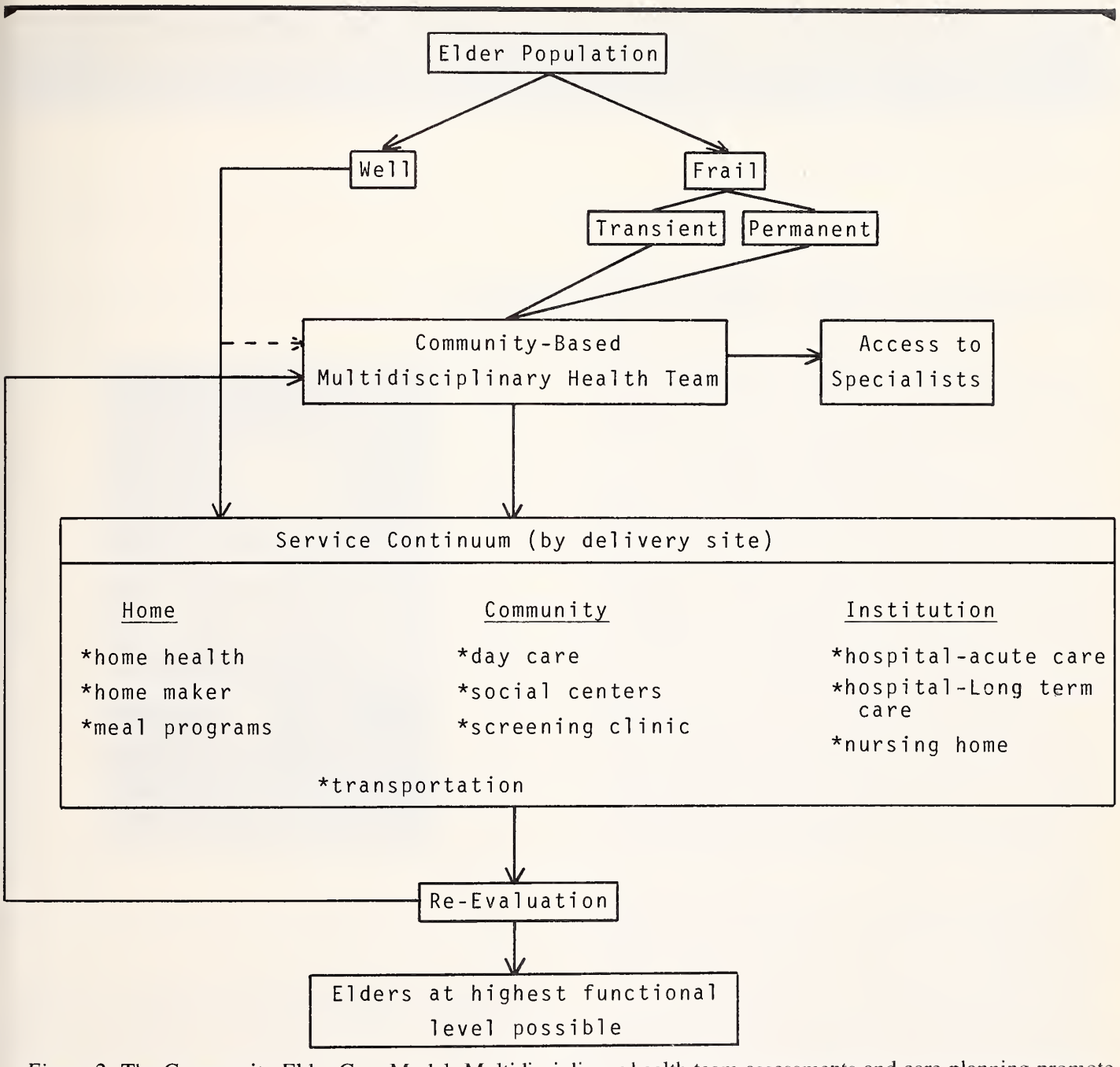


Figure 2. The Community Elder Care Model. Multidisciplinary health team assessments and care planning promote appropriate use of the service continuum. Planned, periodic reevaluations utilizing hospitals and geriatric specialists when needed assure that elders are functioning at the highest possible level.

development of those systems although they are frequently the first contact when patient problems or concerns arise. Increased physician involvement with the long-term care system is critical. The elder must be assured of early entry into a system that identifies broad problem areas and develops preventative and service strategies for those problems so that the elderly may again achieve well status. It is important that physicians take the initiative, through their participation, to assure the proper functioning of community-based assessment systems.

When complex situations arise, access to geriatric specialists in the health and social service disciplines may be necessary. In Great Britian, and more recently in a few U.S. communities, hospital programs have been established to provide inpatient and outpatient geriatric assessment and evaluation services. By conducting enhanced diagnostic work-ups and outlining active rehabilitation and care plans, the geriatric programs can foster maintenance of the

(Continued on page 201)

PRESIDENT'S MESSAGE

Tradition Has Been Broken!



For the first time in its history, the Kansas Medical Society held its annual meeting out of state at the Broadmoor Hotel in Colorado Springs. The facilities were splendid and the weather was superb.

Even more important, there seemed to be an enthusiasm among the delegates and members that hasn't been seen for many years. There was an awareness that medicine is going to have to be more active, even militant, if we are going to be able to protect our professional integrity, the quality of health care, and yes, even our ability to survive in the new competitive environment.

"Medical Ethics in the 80s" was a most intriguing and interesting program. It was presented in connection with the annual Annual Meeting by the Kansas University Medical Center and chaired by Dr. Bob Hudson. This cooperative venture proved to be a beneficial one, and one that should be continued.

The Judicial Council of the American Medical Association also held its meeting as part of our Annual Session, and many members took the opportunity to present the Kansas viewpoint.

The House of Delegates enthusiastically approved the location of this meeting and recommended that it be repeated on a periodic basis. Probably the most significant observation was the presence of different, younger physicians who experienced their awareness of the importance of being involved in organized medicine. Apathy is our greatest enemy!

C. E. Leonard, M.D.

President

EDITORIAL COMMENT

Alliance of Rivalry

"Law is a luxury, medicine a necessity."

The words were those of J. T. Bradley, Topeka lawyer and advocate of the Kansas Medical Society in legislative halls. The year was 1879, the occasion the annual meeting of the society. To be faithful to the context, it should be noted that the immediate concern was getting the legislature to establish effective, state-enforced medical controls. Medical malpractice might have been uppermost in their minds a century later, but to those physicians, confronted with epidemics of a different sort, it was still a specific and personal although painful matter.

The comment may have been one of those generalities stated for effect but invites consideration as to the basic differences between the two philosophies. It is not unreasonable to think that medical care, crude as it was in the beginning, must have carried an urgency of necessity early in the social experience. Not only did the pain and distress of injury and illness call for attention but there was a compelling practical aspect: the maintenance of an effective hunter-warrior cadre to protect the tribe — from the elements, from starvation, and from the enemy. And expendable as women were considered (then), the domestic duties delegated to them functioned better if they weren't interrupted too frequently by death. At any rate, from these beginnings, an element of necessity has been a prime characteristic of medicine and has produced in the profession an undeniable sense of dedication.

Law, on the other hand, acquired a connotation of luxury from its inception. Since the first "laws" consisted of the word of the leader or council and they represented the powers visited on the common tribal member, such privilege undoubtedly qualified as a relative luxury. As social groups grew, they migrated, fought, merged — and became immeasurably more complicated. Much later, the signing of the Magna Carta was seen (by the English-speaking world, at least) as a limiting of the luxury as it curtailed the divine right of kings but, although the barons were pleased because they gained some of the luxuries of law, the villeins and tradesmen and artisans probably noted little change in their own lots.

It is worth noting, too, that many commoners undoubtedly lived out their lives with the fatalistic acceptance that they had no recourse to the luxury of legal representation. Although isolated individuals might offer such services at little or no cost, only in relatively recent times could Everyman expect (even demand) such representation if unable to provide it for himself.

Obviously, there have been significant changes even since 1879 — *especially* since 1879, one might say. From the very beginning, medical considerations prompted some of the first tribal laws. The process has grown from there although medicine frequently damned the form. But the image of *medicine* as a luxury has become increasingly prominent — to physicians confronted by staggering bills for liability coverage (both protection and recompense) and patients confronted with staggering charges for services. There is increasing public belief that sophisticated medical care represents a state of luxury and more voices (at least those not directly afflicted) are calling for curtailments on research, application, and utilization.

So, as law has become a necessary luxury, medicine has become a luxurious necessity — and the twain have met more than we care to admit. It may be that the message is getting through: we can have pie in the sky — medical, legal, or whatever — if we want to pay for it. The real message today is that luxury is a state of mind — but necessity is just as much so as we address the question of where they come together. — *D.E.G.*

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Infant Survival

(Continued from page 190)

age, with particular efforts to reach minorities. These projects offer supplemental services to the usual prenatal care provided in physicians' offices and include public health nursing, home visits and counseling, social work support, nutrition guidance including WIC, and health education with attention to smoking and substance abuse. Following pregnancy, project staff assist mothers in securing child care to continue their education, monitor infants to ensure appropriate medical and preventive health care, and offer family planning services to mothers. During 1983, the infant mortality rate for the M and I participants was 8/1000, almost one-half the rate for a comparable adolescent population.

Unfortunately, these programs reach only one-third of the adolescent population at risk and very few of the women over 20 years at risk. Twice as many low birth weight babies are born to this older group, and only recently have they been targeted by public health programs. The low-birth-weight rate of women over 20 years — although lower than the state average — has not been reduced since 1975. The Academy of Science reports a saving of $3.38 in low birth weight costs for each dollar spent for prenatal programs that target high risk mothers.

Implementation of the strategies recommended by the Institute of Medicine should result in reduction of low birth weight and infant mortality rates in Kansas to the level accomplished by other nations and consistent with the 1990 objectives for the United States.

References are available on request from Dr. Schloesser, Kansas Department of Health & Environment, Forbes Field, Bldg. 740, Topeka KS 66620.

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(Continued from page 195)

highest possible functional level for all elderly. Studies show that nursing home utilization has been reduced in preference for home living when geriatric teams are used. Patient and family morale have increased as have functional abilities of elders when this type of service is available.[12-14]

The value of assessment and care planning is diminished if a continuum of services is not present in a community. Kansas has made great strides in developing a range of services. Ten years ago, nursing homes were the only long-term care services available in most communities. Today, most counties have a core of accessible services including: home health, congregate and home delivered meal programs, senior centers, and senior vans. However, there are more than 50 different types of long-term care services and gaps in the availability of these services.

Well elders may access some elements of the service continuum directly, particularly items like senior centers and screening programs. Well elders also may benefit from an assessment process because they are not always disability free. For example, simple home modification noted from a physical therapy perspective may make the older person's home safer and reduce the risk of falling.

The model applied to frail elders demands that reevaluation occur to ensure that service plans are current and continue to promote functioning at the highest level. Programs that plan, at the onset, for periodic hospital readmissions are one innovative way to ensure appropriate reevaluation of the plan of care.[15] While seemingly contrary to cost cutting principles, planned inpatient evaluations can prevent later costly acute inpatient care by updating care plans in light of changes in the older person's functional status. By evaluating the patient's response to drug regimens and making appropriate modifications, drug utilization is often decreased. Because the elderly use 30% of all drug prescriptions, cost savings could be substantial.[16] An additional benefit is the "respite" for the family from the physical and psychological demands of caring for an older person at home. Ultimately, programs of planned periodic readmission enhance the "community survival" of the elderly.

The model may be financed by several sources. Income levels for people 65 years and older are increasing, and there is a growing "private pay" market for long-term care services.[17] Insurance companies are exploring this potential market, but to date the few available policies focus on institutional long-term care.

Public reimbursement programs are being modified to incorporate a broader range of long-term care services. Medicaid in Kansas operates the Home and Community-based Services Program which offers potential nursing home residents the option of several support services. Medicare has expanded policies that will allow more elderly to join health maintenance organizations. Most impressive, though, are federal programs to develop social/health maintenance that provide both social services and health care on a capitation basis.[18] Experiences with well and frail elder populations indicate that risk-sharing programs could be effectively established.

The Elder Care Imperative

While society generally is concerned with meeting the needs of a burgeoning older population, the traditional health system has not been oriented to address all factors that impact on the health of the elderly. Social, economic, and environmental factors need to be considered along with traditional medical concerns. A few long-term care models exist for replication, but new approaches are needed. The Kansas health care system must adopt and develop a model to promote the functional health status of the older population. Physicians are in a position to assume a leadership role in this development.

Many Kansas communities are already in the 21st century in that more than 20% of their population is now age 65 years and older.[3] Clearly the elder care imperative in Kansas is here.

Acknowledgement

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References are available on request from Dr. Hollowell, Kansas Dept. of Health & Environment, Forbes Field, Bldg. 740, Topeka KS 66620.

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Changing Concepts

(Continued from page 186)

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1947 — The division of hospital facilities and division of mental health were established.

June 6, 1946 — The Kansas Public Health Association established the Samuel J. Crumbine Award for Outstanding Contributions to Public Health. The first award was presented to Dr. Crumbine in Wichita on this date.

1949 — The infant death rate was 31.3 deaths/1,000 live births.

1950 — The adult boarding home licensing law was adopted.

1953 — The first district nurses were employed by the board.

1953 — A home accident prevention program was started with a grant from the Kellogg Foundation.

1955 — A polio program was started with federal funds.

1955 — No deaths were reported from typhoid fever and no cases of smallpox were reported.

1956 — The infant death rate was 26.7/1,000 live births.

1961 — The first study of migrant health programs was carried out in the state.

1962 — More than 1,000,000 Kansans were immunized against polio on two successive Sundays.

1966 — The comprehensive health planning act was passed setting up statewide and local health planning.

July 1, 1974 — The Kansas Department of Health and Environment was created with a cabinet-level secretary appointed by the governor. Dwight F. Metzler, an engineer, became the first secretary.

1975 — The Food Service and Lodging Board was abolished and responsibilities transferred to the new department.

Nov., 1975 — The Early Intervention Screening program was started.

1976 — The Kansas Health Planning and Development Act and the Kansas Certificate of Need Act were passed.

1979 — The first work-site health promotion program was started.

1985 — The Certificate of Need law was abolished by the legislature.

1985 — The Legislature passed a law banning the in-ground burial of hazardous wastes in the state.

1985 — The infant death rate has dropped to below 10 deaths/1,000 live births.

ROSTER

The 1985 Roster will appear in the August issue of KANSAS MEDICINE. NOW is the time to make sure that the information is accurate and up to date. Please examine your listing in the 1984 Roster and advise us of any corrections we need to make.

If you are unable to locate your 1984 Roster, contact the Kansas Medical Society (1-800-332-0156) and we will check the information for you.

IMPAIRED PHYSICIAN PROGRAM DIRECTORY

For information concerning the Impaired Physician Program of KMS or to get help for an impaired colleague, yourself or your spouse, please contact the KMS office or the contact person in your area. All information and identities will be held in strictest confidence, and the caller need not identify himself or herself.

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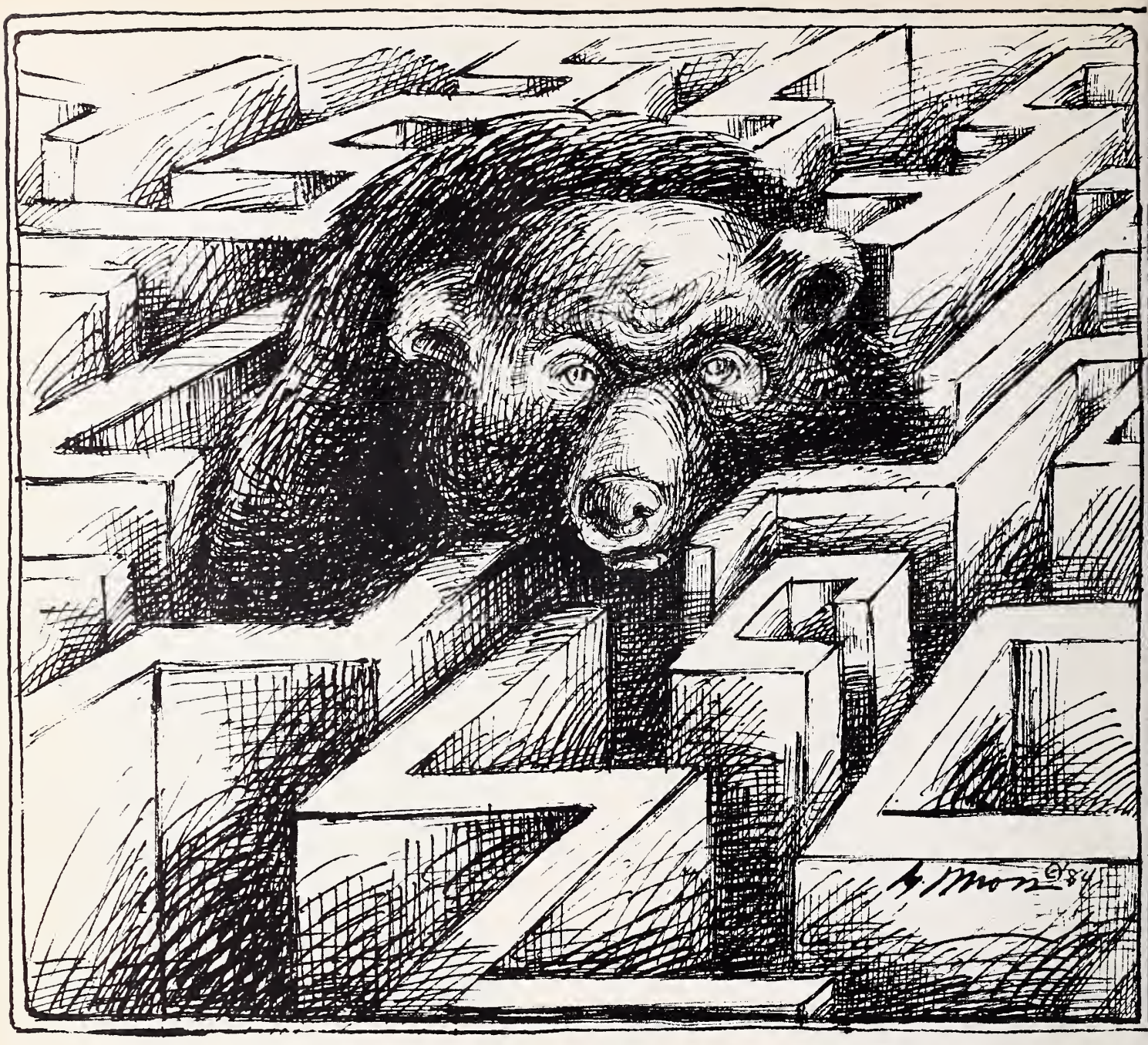
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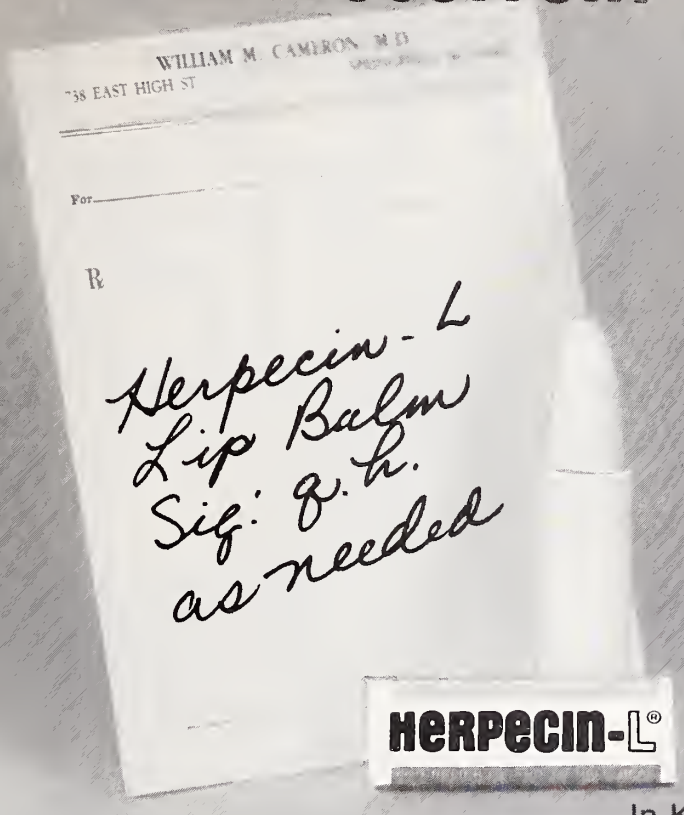
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Kansas Public Health Labs

(Continued from page 192)

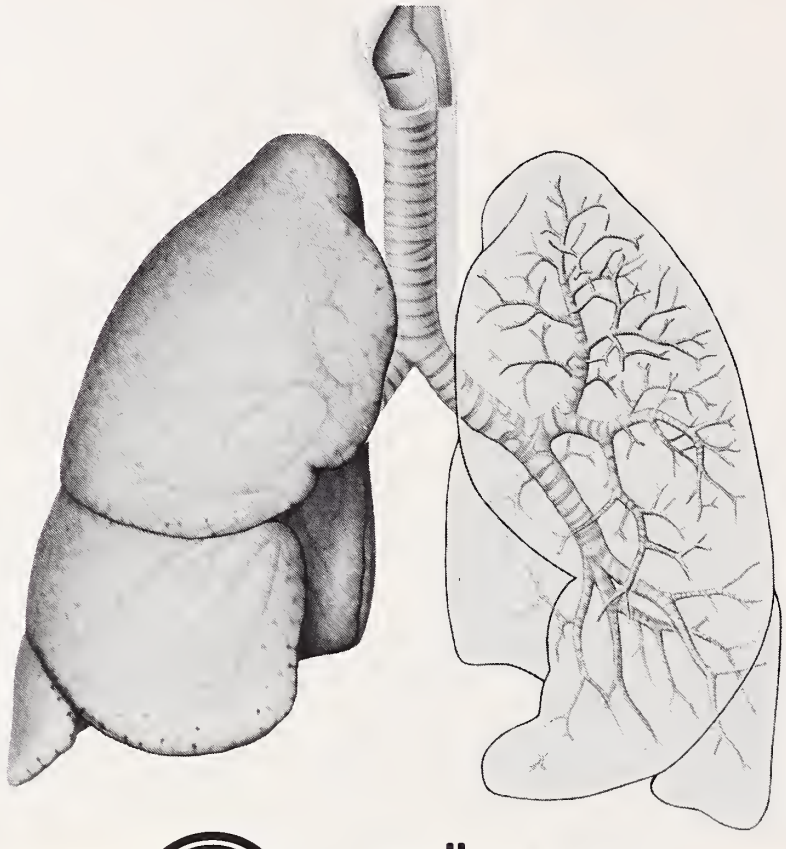
proved to be an effective deterrent to lifelong mental retardation. Screening programs using dried blood spots mailed to the state laboratory began in 1965 and will be consolidated to include mandatory screens of all Kansas newborns at the State Laboratory following passage of legislation in 1985. Toxicological examination of body fluids and tissues are performed to assist in determining the cause of unattended deaths. Twenty-five hundred blood and open container alcohol specimens are analyzed each year to assist in removing the drinking driver from Kansas highways.

Environmental chemistry laboratories include inorganic, organic, and radiation units. Trace levels of toxic chemicals in air, surface waters, drinking waters, groundwaters, chemical spills, and hazardous wastes are detected and quantified using samples obtained from throughout the state. Water samples may be screened for as many as 26 inorganic parameters and 129 priority pollutant organic species using $2 million worth of computerized analytical instrumentation. Radiochemical laboratories screen all public water supplies for radioisotopes which result from natural geological formations and also monitor activity levels in air, water, vegetation, and animal life within 50 miles of the Wolf Creek Nuclear Power Station.

Laboratory Certification/Improvement. Laboratory certification and improvement programs work with 160 hospital and independent clinical laboratories, 125 private, municipal and industrial environmental laboratories, and 625 certified breathalyzer operators in 45 law enforcement agencies in the state. Through technical training, performance evaluations and on-site inspections, these programs insure that Kansas clinical, environmental, and law enforcement laboratories meet minimum acceptable standards and can produce laboratory data of good quality.

The Kansas public health laboratory has evolved through 100 years of scientific development and cooperation with Kansas physicians and health care providers. The century ahead will be no less challenging in our joint efforts to provide good health and a safe environment for all Kansas citizens.

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

{0617B2R}

Note. Ceclor*: (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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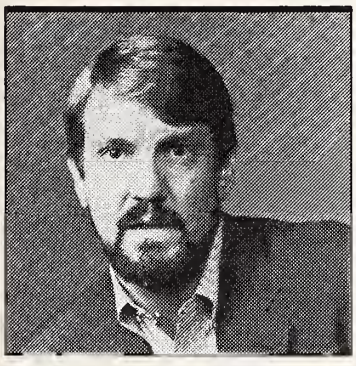
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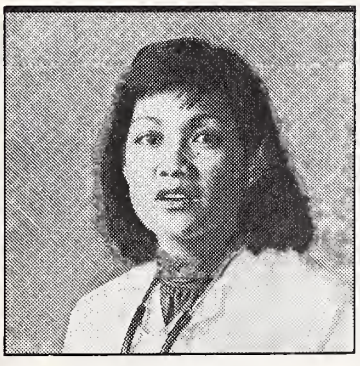
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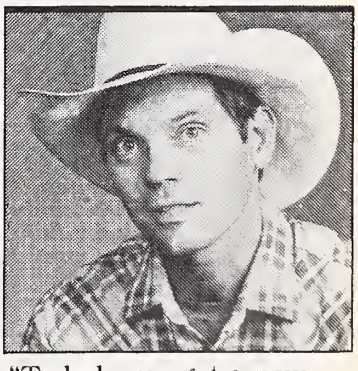
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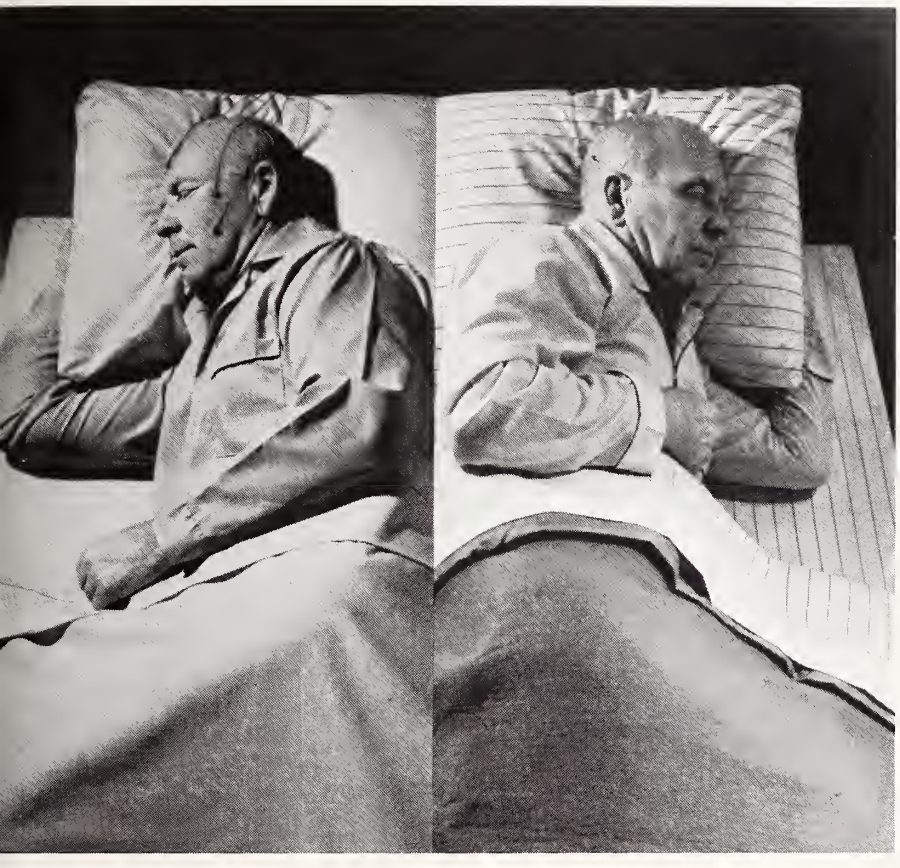
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References: 1. Kales J *et al*: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 2. Kales A *et al*: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 3. Kales A *et al*: *Clin Pharmacol Ther* 19:576-583, May 1976. 4. Kales A *et al*: *Clin Pharmacol Ther* 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 6. Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. 7. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 8. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 9. Amrein R *et al*: *Drugs Exp Clin Res* 9(1):85-99, 1983. 10. Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. 11. Greenblatt DJ *et al*: *Sleep* 5(Suppl 1):S18-S27, 1982. 12. Kales A *et al*: *Pharmacology* 26:121-137, 1983.

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Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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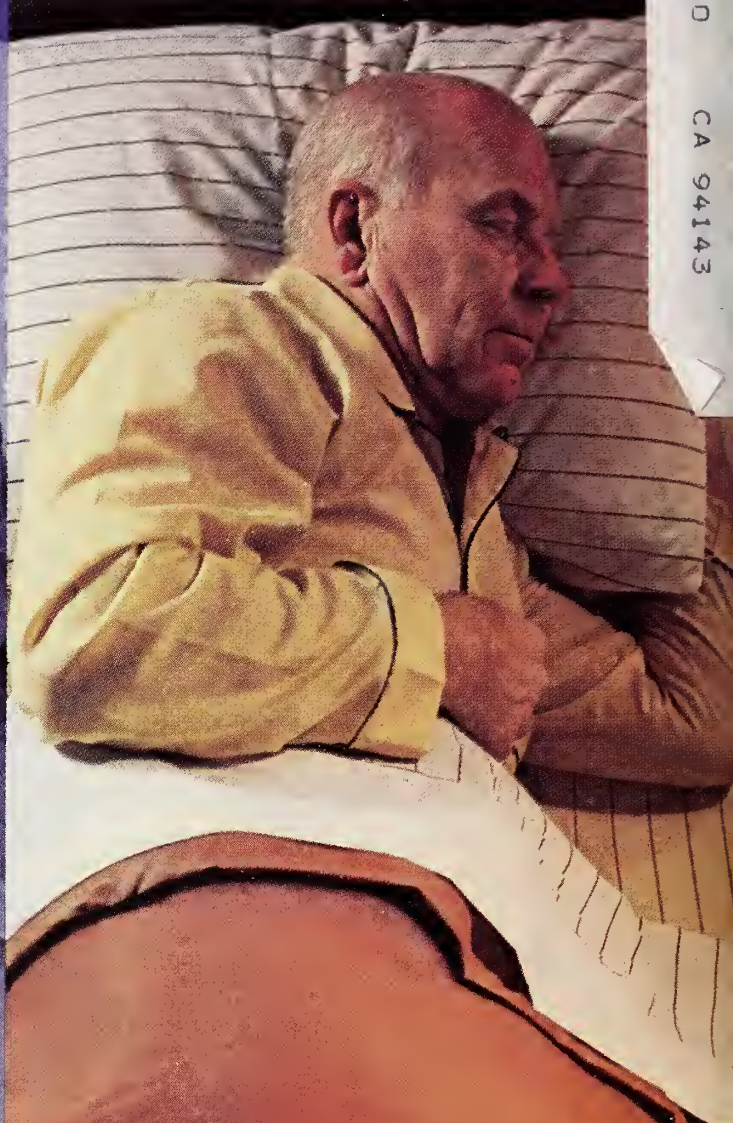
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KANSAS MEDICINE

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• Pregnancy with IUD *in situ* 231

KANSAS MEDICINE

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Volume 86, Number 7, July 1985

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THE COVER: This scene, entitled "Endless Prairie Parade," is a watercolor by Wichita artist Charles Sanderson, and is included in the book, *The Kansas Landscape*, published by the Kansas Department of Economic Development and *Kansas!* Magazine. The show of 32 original paintings is currently touring Kansas communities. The book is available for $6 from *Kansas!* Magazine, 503 Kansas Avenue, Topeka KS 66603.

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Coming in August . . .

THE 1985 MEMBERSHIP ROSTER

The August issue of KANSAS MEDICINE will include the new membership roster and additional important information. Each KMS member will receive one copy. Additional copies are available to MEMBERS ONLY at $12 each. NON-MEMBERS may order copies for $25 each.

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Make check payable to the Kansas Medical Society and mail to 1300 Topeka Avenue, Topeka KS 66612.

AMA DELEGATE REPORT

Unified Membership

Editor's note: The 1985 House of Delegates adopted Resolution #85-12 that mandates unified county-state-national membership effective January 1, 1986. This is the second in a series of short messages to Kansas physicians presented by members of the Kansas AMA delegation.

The 1985 House of Delegates voted almost unanimously to endorse unified membership. This represents a rather sudden change in policy — one you will see repeated by many state societies during the next two to five years. Here are some of the reasons:

- There is the growing perception that only the American Medical Association can speak for organized medicine. No specialty group has the staff, resources, or liaison offices to Congress.
- To speak effectively, the AMA must represent the majority of physicians in the nation (fewer than 50% of physicians are now members).
- Most important is the need to organize to resist the tyrannies of multi-level government — the regulations, setting of fees, unconscionable cost shifting, the idiocy of refusing payment for certain medications and procedures where delay and denial create greater costs later.

To paraphrase Franklin, if we do not stand together, we shall certainly fall separately.

Alex Scott, M.D., Junction City
AMA Delegate

1984 Elections: The Medical Aftermath

"Enough is enough!"

ALTHOUGH the Reagan Administration won reelection by an overwhelming majority, the Democrats have gained more power in the Senate and solidified their hold over the House. Pressure to control the nation's $200 billion deficit has driven the Reagan Administration to seek further cuts in Medicare, while the Democrats may attempt to revive some new form of national health insurance. Whatever happens, physicians nationwide should be informed so they can take an active role in the process.

As Dr. Boyle said in his address to the interim meeting of the AMA House of Delegates, "Enough is enough!" Physicians have a duty to be patient advocates fighting for quality in times of cost-cutting. As an AMA member, you can take part in this noble struggle.

Already, a plan to freeze Medicare payment rates to hospitals and physicians has been suggested by the administration. Medicare, which is expected to cost $71.3 billion in 1985, serves approximately 30 million elderly Americans. According to White House officials, the plan being considered would:

- Freeze rates Medicare pays hospitals for each patient at current levels during fiscal 1986, rather than increasing them to keep pace with inflation as earlier planned;
- Extend a freeze on rates paid to physicians for Medicare services. The current 15-month freeze, approved by Congress which began July 1, 1984, would continue through December, 1986;
- Raise Medicare Part B in increments over four years beginning in 1986, eventually leading to the goal of 25% recipient financing of the physicians' service component of the program;
- Allow the $75 Part B deductible that patients must pay out of their own pockets for physicians care to rise annually to keep pace with inflation;
- Reduce Medicare assistance subsidies to teaching hospitals.

Whether this plan actually becomes law still remains

to be seen. So far, response from the medical community, as well as from senior citizen groups, has been particularly critical of the proposed plan.

According to John Coury, Jr., M.D., chairman of the AMA's Board of Trustees, the proposal shows "a total disregard for the elderly." He adds: "Most physicians will continue, as we have been, with the fee freeze, but there is a certain percentage who have very high overheads in their specialties. They're paying liability insurance of $1,000 a week. They can't remain frozen for an indefinite period of time.

"They are willing to bite the bullet, but they will bite it for so long, and that will be it," he concludes.

On the other side of the aisle, the Democrats' health care agenda calls for limiting what health care providers can receive as reimbursement, passing some sort of comprehensive national health insurance, and adopting across-the-board health care cost-containment legislation.

Specifically, it is the "Kennedy-Gephardt" bill that the Democrats are expected to push in the coming months. The bill provides for a radical restructuring of reimbursement for inpatient services for both hospital and physician services, without a single demonstration as to how such a system could work and what effects it would have on health care delivery and the health status of the population.

Last fall, the AMA voiced its opposition to the bill before a House Subcommittee, stating: "The very fact that the bill calls for studies on how to maintain a high quality of services while constraining the rate of increase in costs only points to the fact that the bill is 'putting the cart before the horse.' Its stress is totally cost-containment. There is hardly a word on quality of or access to care."

The testimony added, "The bill would result in rationing of health care services because of its arbitrary establishment of hospital revenue caps. It would establish incentives for hospitals and physicians to reduce services — a goal that is usually tied to a reduction in the overall quality of health care services."

Finally, it concludes, "If enacted, the Kennedy-Gephardt proposal would inevitably spawn enormous amounts of federal regulations to implement, monitor and enforce the law."

The American Medical Association has responded to the cost-cutting clamor by proposing a number of its own cost-effectiveness programs. These include: The Health Policy Agenda for the American People, a cost-effectiveness advisory program organized by representatives of 150 organizations from a wide range of health care interests; the National Commission on the Cost of Medical Care, an effort to seek cost-effective solutions without decreasing the quality of care; the Cost-Effectiveness Network, an organization of physicians and hospital staffs who experiment with efforts at decreasing costs; and the monthly *Cost-Effectiveness Bulletin,* that provides a communications network to members of state and county medical societies for cost-effectiveness reporting and information sharing.

Whatever happens in the next few months, it is obvious that the AMA must remain vigilant. To do this, the AMA needs your help. Membership in the Association supports rational approaches to make health care cost-effective without jeopardizing quality, addresses the types of legislation described here and enhances the medical profession's ability to help ensure health care access for all Americans for years to come.

Official Proceedings

1985 Annual Meeting of the House of Delegates

Transactions of the 126th Annual Session of the Kansas Medical Society are published in this issue of KANSAS MEDICINE.

The resolutions are printed in numerical order following the minutes of the Second House of Delegates session. Those resolutions that were not adopted but were referred for further study or information are so indicated. The resolutions that failed to pass are retained in the official minutes at the executive office, but are not reported here.

FIRST SESSION

The first session of the House of Delegates of the Kansas Medical Society convened on Friday, May 3, 1985, beginning at 8:30 A.M. at the Broadmoor Hotel, Colorado Springs, Colorado. The meeting was called to order by G. Rex Stone, M.D., Speaker. He introduced F. Calvin Bigler, M.D., President, who welcomed the 126th Annual Session of the Kansas Medical Society.

Dr. Bigler explained that this was the first KMS session ever held outside Kansas, but noted that the boundaries of Kansas Territory prior to statehood included the meeting locale. He wished for those assembled a good learning and decision-making experience and encouraged them to have fun at this beautiful location.

Dr. Stone briefly reviewed the order of business for the day and explained that the House was composed of elected officers, past presidents, representatives of specialty societies, and the duly elected delegates from the component medical societies. He stated that the House would follow the *Sturgis Standard Code of Parliamentary Procedure*.

The composition of the Reference Committee was announced as follows: Edwin D. Rathbun, M.D., Liberal, Chairman; Stephen F. Miller, M.D., Parsons; Charles S. Reeves, M.D., Fort Scott; Jay S. Schukman, M.D., Great Bend; and Arthur D. Snow, Jr., M.D., Shawnee Mission.

The Speaker announced the presence of a quorum. Minutes of the 1984 meeting were approved. The following were appointed as tellers for the primary election: Alex Scott, M.D., Junction City, Chairman; John P. Brockhouse, M.D., Emporia; and Rex R. Fischer, M.D., Manhattan.

The Speaker ordered distribution of the primary ballots. There being no additional nominations from the floor, members voted for the following slate:

PRESIDENT ELECT: Franklin G. Bichlmeier, M.D., Kansas City

FIRST VICE PRESIDENT: Donald W. Hatton, M.D., Lawrence

SECOND VICE PRESIDENT: Robert J. Haskins, M.D., Chanute; Erwin T. Janssen, M.D., Topeka; Terry L. Poling, M.D., Wichita

CONSTITUTIONAL SECRETARY: Dean T. Collins, M.D., Topeka; Richard M. Skibba, M.D., Wichita

TREASURER: Thomas L. Taylor, M.D., Shawnee Mission; Roger D. Warren, M.D., Hanover

AMA DELEGATE 1986-87: Lew W. Purinton, M.D., Wichita

AMA ALTERNATE DELEGATE 1986-87: Jimmie A. Gleason, M.D., Topeka

Dr. Bigler presented the slate for the House of Delegates officers as follows: Speaker: G. Rex Stone, M.D., Manhattan; Vice Speaker: Edwin D. Rathbun, M.D., Liberal; Joan Sehdev, M.D., Topeka.

The Speaker asked Clair C. Conard, M.D., to introduce the special guest. Dr. Conard explained that the American Medical Association has sent representatives to various states to facilitate communications. He then introduced John J. Coury, Jr., M.D., Chairman, AMA Board of Trustees. Dr. Coury is the unopposed candidate for the office of AMA President Elect.

In addressing the House, Dr. Coury explained the AMA budget (projected at $140 million for 1986) and the extended services it now provides. Only 45% of expenditures is supported by dues; 55% comes from investment income. Costs of litigating such issues as chiropractic, professional liability, federal government's fee freeze, and other issues are considerable. Dr. Coury admonished physicians not to apologize for the quality of care but to continue to practice quality, cost-effective medicine, without compromise of medical ethics. His words, "Stop apologizing for the cost of medicine and start explaining it," met with the Delegates' concurrence. He suggested that physicians discuss costs with their patients and explain the need for medical procedures when indicated.

Dr. Stone recognized Dr. Fransen for his efforts as Vice Speaker. He then called on committee chairmen for remarks in addition to the prepared reports which were distributed to the Delegates. Those reports appear elsewhere in these Minutes.

Constitutional Secretary — Richard M. Skibba, M.D.

Categories	*1981*	*1982*	*1983*	*1984*	*1985*
ACTIVE MEMBERS	2,146	2,225	2,218	2,288	2,365
ACADEMIC MEMBERS					1
FIRST YEAR ACTIVE MEMBERS			16	18	13
PROBATIONARY MEMBERS	54	79	68	57	48
ASSOCIATE MEMBERS	5	3	5	6	8
INTERN/RESIDENT MEMBERS	23	37	34	63	50
DELINQUENT MEMBERS	165	102	194	110	127
Dues Exempt:					
EMERITUS MEMBERS	133	130	144	149	143
HONORARY MEMBERS	1	1	1	1	1
LOA/PERSONAL EXEMPT MEMBERS	40	24	26	28	27
RETIRED MEMBERS	165	167	200	209	244
SERVICE MEMBERS	15	15	16	13	10
STUDENTS	4	8	38	345	464
Totals	2,751	2,791	2,960	3,287	3,389

Roger D. Warren, M.D., Treasurer, stated that his report had been distributed to the Delegates. Included in that report was the financial statement for the Professional Liability Fund. Dr. Warren said that in the future this fund should include a line item for interest accrued on the unused balance.

The Speaker, in calling on Dr. Gray for the Necrology Committee report, asked all present to stand in recognition of the colleagues whose deaths had been reported since the last meeting.

Necrology Committee — David E. Gray, M.D., Chariman

I do not fear you as a foe,
you are my shadow where you go.
In spite of you I live my fill
and life is full and sweeter still.
How else could living be so sweet
if there were not a last defeat?

(Samuel Stearns, M.D., "Be My Companion, Death," from *Perspectives in Biology and Medicine,* 27 (4), 1984; reprinted with permission)

Name & Address	*Age*	*Date*
Virgil M. Auchard, M.D., Lawrence	95	10-12-84
James L. Beaver, M.D., Wichita	74	5-20-84
Paul L. Beiderwell, M.D., Topeka	76	9-7-84
Donald A. Bitzer, M.D., Washington	81	1-30-85
Charles S. Brady, M.D., Atchison	73	1-19-85
Robert L. Braunsdorf, M.D., Topeka	77	2-9-85
Eugene J. Bribach, M.D., Atchison	101	12-13-84
John J. Casey, M.D., Wichita	59	5-23-84
Walter T. Elnen, M.D., Wichita	80	7-4-84
Robert A. Gollier, M.D., Ottawa	71	6-3-84
John A. Grove, M.D., Newton	76	9-9-84
George W. Hammel, M.D., El Dorado	76	8-8-84
Robert B. Hodgson, M.D., Wichita	61	5-8-84
Frederick E. Johnson, M.D., Topeka	92	11-18-84
Peter S. Loewen, M.D., Hillsboro	92	5-26-84
John C. Mitchell, M.D., Salina	71	11-29-84
Victor North, M.D., Wichita	66	7-11-84
James G. O'Shea, Jr., M.D., Jetmore	66	12-4-84
Stephen B. Phillips, M.D., Manhattan	66	8-11-84
Will D. Pitman, M.D., Pratt	85	3-9-84
Lloyd W. Reynolds, M.D., Hays	73	6-25-84
James T. Robison, M.D., Kansas City	63	12-16-84
Vincent L. Scott, M.D., Wichita	81	4-14-84
Frederic Speer, M.D., Shawnee Mission	75	3-8-85
Clyde B. Trees, M.D., Topeka	76	3-10-85
Thornton L. Waylan, M.D., Nashville	76	10-28-84
Alvin Y. Wells, M.D., Winfield	87	11-25-84
Jacob T. Whallon, M.D., Wichita	69	8-25-84
Robert W. Wright, Jr., M.D., Kansas City	60	1-26-85

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Editorial Board — David E. Gray, M.D., Chairman

I continue the annual ritual of bringing the greetings of the Editorial Board to the membership although I don't recall having to travel so far to do it before. As you gaze out of the window, you may get the feeling that Kansas never looked like this although indeed it did in those territorial days when our founders begat us—and it was customary to claim all the land you could get away with. But be not dismayed. You will find in your endeavors that meetings rooms look the same wherever you are.

In reporting to you on the status of our product, KANSAS MEDICINE, I hope it is unnecessary to advise you that it is the same journal I have been telling you about these many years. Its current form has some obvious differences in addition to its name but if I have to enumerate them at this point, my cause is already lost.

Although pride makes me assume that you are aware of these changes, I do want to mention one item that has not changed, our logo, which students of heraldry will recognize as fouled stethescopes rampant on a field of whatever is handy. It was just 50 years ago that this was created for us by Bradbury Thompson, a product of Washburn and Topeka, who has gone on to the highest levels of performance and honor in the field of graphic illustration—longtime professor at Yale, designer of numerous magazines and stamps and the Washburn College Bible, and winner of many national and international awards. You can understand my determination, therefore, that it be retained even modestly in this, the fourth change in our cover since that time.

I can report what should be of interest to you and at the same time extend the board's thanks to the Business Manager who, although he has been known to go to the mat when necessary, is not to be confused with Sergeant Slaughter. The financial status of KANSAS MEDICINE as well as its prospects are encouraging. We still have carry-in sandwiches at the board meetings rather than the steaks of pre-inflation times and await the periodic financial reports with some trepidation, but we have been moved out of intensive care.

This improved condition is the product of several factors. Our publication economies are apparent and have been no more palatable to the board than to the membership. The changes that have been made in the last few months, however, have been accomplished with fidelity to them and we entertain the hope of bringing expansion in various forms if our finances improve.

In another direction, we have increased our advertising rates significantly which, I confess, was somewhat disquieting to me in prospect. Our advertisers have accepted the change with sufficient equanimity to lead to mixed feelings on our part — pleasure at the increased revenue, regret that we didn't do it sooner. We have also procured the services of Advertising Productions, Inc., an advertising agency, to promote in-state advertising. Meanwhile, the State Medical Journal Advertising Bureau, which promotes national advertising for us, has made some internal changes which have already been beneficial. Finally, although we admit it required some change in philosophy, we now unashamedly invite you to get your lights out from under their bushels and announce your presence to your colleagues through our newly established Physicians' Directory — for a small fee, of course.

As you can imagine, the changes of the past year have imposed no small burden on the Managing Editor and Editorial Assistant. Veterans of these sessions know that my chief interest in making my reports is to have the opportunity to express the board's — and in particular my own — appreciation to Val Braun and Eleanor Bell for getting your journals to you. This year, more than any other of my tenure, this has been true.

Finally, then, this society's records will always carry the stamp of that remarkable individual who has presided over its efforts this year, Calvin Bigler. The board is pleased to recognize him with the traditional bound volume of KANSAS MEDICINE for his services to us, not the least of which is that under this loyal son of Eli, we have not — yet, at least — been subjected to the Whiffenpoof Song.

At this point, the following results of the primary election were announced:

The slate for the office of Second Vice President will consist of Robert J. Haskins, M.D. and Terry L. Poling, M.D.

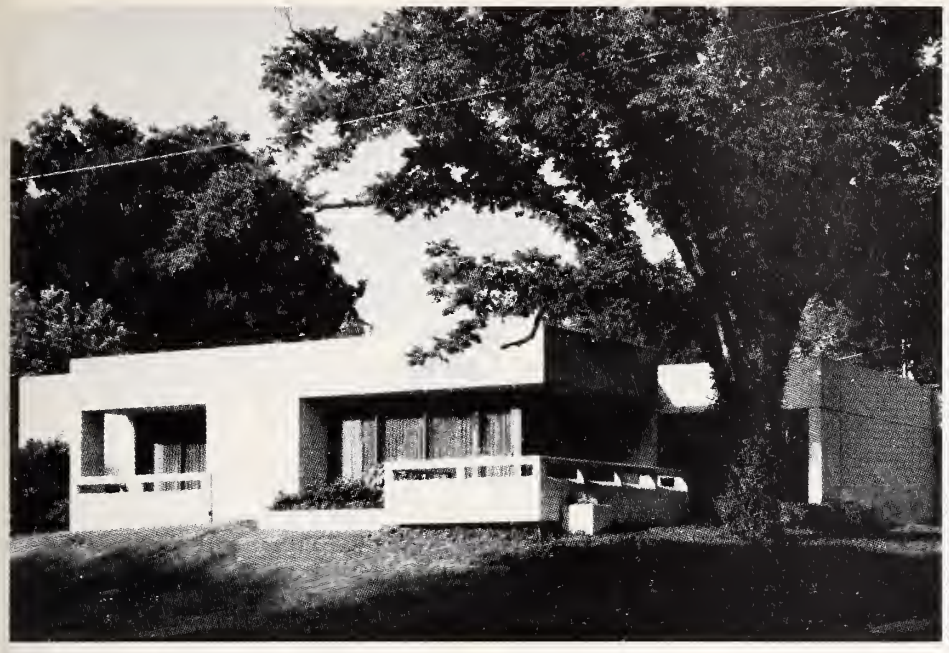
Professional Liability Committee — Jimmie A. Gleason, M.D., Chairman

Dr. Gleason explained SB-110, stating that the two-year KMS professional liability project is on schedule. Attempts will be made this summer to considerably strengthen this year's legislation. Dr. Gleason expressed gratitude on behalf of his committee to the numerous physicians who contacted their legislators concerning this problem. An equal effort will be required next year to achieve the desired results.

The House accorded a standing ovation to Dr. Gleason, Jerry Slaughter, Wayne Stratton, and Dr. Linda Warren for their splendid work and achievements in the area of professional liability legislation this year.

Jerry Slaughter, Executive Director, then presented the Distinguished Service Award to Wayne P. Stratton, J.D., KMS Legal Counsel, with the following remarks:

"This morning we recognize a person who is





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essential to the work of the Kansas Medical Society. It is said that no one is indispensible, but in this case we have to make an exception. During the course of the year, I constantly rely on this person for sound, balanced advice. I rely on him for a perspective that has proven over the years to be sensible and reasonable.

"We are extremely fortunate to have Wayne Stratton as our General Counsel. For ten years, Wayne has guided the Kansas Medical Society through complex legal and legislative issues. His credentials are impeccable, his loyalty unimpeachable, his record is the envy of his colleagues.

"His voice is a respected one in the legal arena. Wayne is not only a leader in health care law, he is simply the best in his field.

"I am deeply indebted to Wayne. His meticulous research and well written opinions and legislation make my job much easier. Wayne's experience as a defense counsel in medical malpractice cases has been invaluable to us in our legislative efforts. We simply couldn't do it without him.

"So it is with a great deal of pride and admiration that I present Wayne with the 1985 Kansas Medical Society Distinguished Service Award in recognition of his ten years of outstanding and dedicated service to the physicians of Kansas."

KMS Auxiliary —
Ann Rempel (John), President

Thank you for inviting me to speak to you today. I bring you greetings from your Auxiliary, and I thank you for the support you give us both in spirit and financially. I come before you with pride in the Kansas Medical Society Auxiliary and with feelings of humility that I have had the opportunity to serve as its 60th President.

The Kansas Medical Society Auxiliary celebrates its Diamond Jubilee in a time of turmoil, a time of change, a time of trail lawyers. It is also a time for new opportunities in community services.

According to our Bylaws, "The purposes of the Kansas Medical Society Auxiliary shall be exclusively educational and charitable. They shall be:

- to assist in those programs of the Kansas Medical Society, American Medical Association, and the American Medical Association Auxiliary that improve the health and quality of life of all people;
- to promote health education;
- to encourage participation of volunteers in activities that meet health needs;
- to coordinate and advise concerning the activities of county auxiliaries; and
- to support health-related charitable endeavors.

Auxilians across Kansas have been involved this past year in a variety of projects. Professional liability forums to inform the public; AMA-ERF fund raising to ensure the continuation of quality medical education; health careers loans; health screening endeavors; and community coalitions are just a few of our projects. We hosted six Forums on Aging across the state.

We gave scholarships, we raised nearly $6,000 for two Ronald McDonald houses. We led substance abuse prevention seminars — with a nationally-recognized expert, Dr. Marsha Schuchard — in three cities, and took the information home to begin new projects in our counties. We prepared radio spots and we learned about press releases, fetal alcohol syndrome, DRGs, and family stress. We gave support to each other in times of trouble. We collected printed materials, drug samples, eye glasses and things that are usually thrown away, and then we shipped those items to eight other countries and to World Medical Relief. We presented programs on child abuse prevention, and conducted teenage pregnancy surveys in three cities.

We registered medical families to vote and then turned them over to KaMPAC for recruitment. We campaigned for candidates favorable to medicine, we walked precincts, stuffed envelopes, and contributed our money — and yours. Four of our members were reelected to serve in the Kansas Legislature. We wrote letters, telephoned, and visited the Capitol. We joined together for our best attended Day at the Legislature in many years — perhaps in our history.

We appreciate the help you give us in these efforts, the encouragement that comes from your Executive Committee, the able assistance and cooperation of the entire KMS staff, and I offer a very personal thanks to Val Braun who often keeps us from "falling on our face." We certainly appreciate her.

There is much more we want to accomplish because we think these projects promote better public relations for organized medicine.

To accomplish more we need your help. We need more members — members to carry on these worthy jobs and their dues to finance the projects. We have half as many members as the Kansas Medical Society, and I refuse to believe that half of you are single. If your spouse doesn't belong to KMSA, then I ask you to give her a membership in all three levels of

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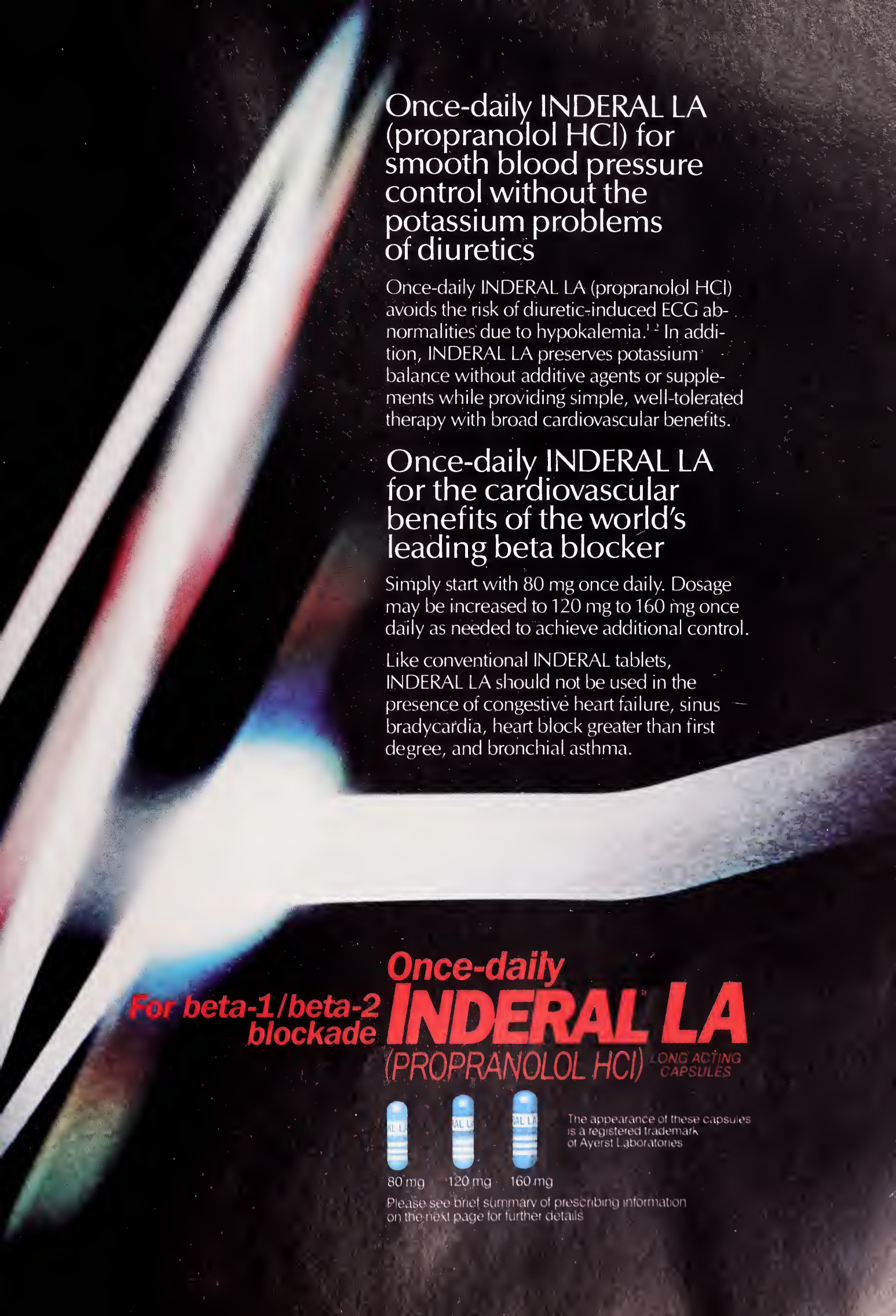
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Please see brief summary of prescribing information on the next page for further details

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INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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When people ask me, "What *is* the Kansas Medical Society Auxiliary?" I tell them, "KMSA members are just ordinary people doing *extra*ordinary things." I'm very proud of them!

Mrs. Rempel then presented AMA-ERF contributions for the past year to the University of Kansas School of Medicine. Acknowledging the gifts were Joseph C. Meek, M.D., Kansas City, and William J. Reals, M.D., Wichita. This concluded Mrs. Rempel's presentation, whereupon she received a standing ovation from the House.

The Assembly next heard from Mrs. Ann Pitchford, El Paso, Chairman of the AMA Auxiliary Legislation Committee. Mrs. Pitchford stated that the 80,000 members of the American Medical Association Auxiliary share the concerns of medicine today and stand ready to help meet the challenges.

Continuing with supplemental committee reports, the Speaker called on Roger D. Warren, M.D. Dr. Warren, KaMPAC Chairman, introduced the new KMS staff person, Marsha Hutchison, who will be working with KaMPAC. He acknowledged the help of Gary Caruthers and thanked him for the able assistance rendered during past years. Dr. Warren then discussed the KaMPAC financial report.

Committee on Health and Environment Liaison
Richard Meidinger, M.D., Chairman

The action of the Subcommittee has consisted of active dialogue directly with Health and Environment Secretary Barbara Sabol; Joseph G. Hollowell, Jr., M.D., Director of Health; and various section chiefs within the Department. We have not had a meeting of the full Subcommittee since the current issues did not seem to warrant that so far this year. The following issues have been addressed:

Kansas Hospital Regulations are being updated for the first time since 1974. We have solicited comments from specialty sections, local medical societies, and pertinent KMS committees. Also, input has been generated through the Kansas Hospital Association and multiple interested parties. The regulations were initially presented for adoption last November, but ran into such general opposition that they have gone back to the drawing board to be completely rewritten in most sections. I look for additional hearings to be held this summer. We will keep you informed.

CON. The Certificate of Need legislation will cease to exist as of July 1, 1985. There is no replacement legislation. The legislature feels strongly about "free enterprise" activity, while Secretary Sabol is watching this issue very carefully and can institute federal regulation entitled 1122 at any time, which imposes the federal guidelines for health planning and certificate requirement. It can be done at the executive level, with the Secretary making recommendation to the Governor, and the Governor signing the federal contract. This would impose $2 million construction limits and several other dollar limits before CON or Certificate of Planning is needed.

Health Facilities Study is a five-year program under SHCC, designed to benefit local, state, and federal governments and private industry in planning adequate health care delivery systems. This would include acute care hospitals, adult health care homes, ambulatory surgical centers, psychiatric hospitals, renal dialysis centers, alcoholic treatment centers, rest homes, etc. These will be surveyed to establish standards regarding renovation needs, service gaps, excess capacity, and access problems. These standards will serve as guidelines and will not be enforceable.

Radiation Equipment Fees have been mandated by Senate Bill 414, passed in 1983, to develop and impose fees for radiation producing device registration and radioactive material licensing programs. There have been multiple public hearings, beginning in November 1984 and continuing, primarily concerned with these regulations and the registration fees. Currently, no charges are made for registration of the equipment or of radioactive licensure. The legislation requires a fee to be set to regain part or all of the cost of inspection and registration.

All of the regulations submitted appeared satisfactory at the public hearings except for the fee range. These fees would be imposed on all practitioners with radiation producing devices including X-ray units, nuclear medicine radiopharmacies, teleradiology, and industrial radiology devices. The fees proposed were $60 for the first X-ray machine and $50 for each additional machine for standard X-ray equipment; $50 for dental machines; $530 for nuclear medicine license with a $40 charge per amendment, and $650 for radiopharmacy licenses. Industrial registration charges would vary from $750 to more than $1,500, depending on the type of radiation device used. The Department of Health and Environment has no choice in the matter, but must employ some sort of fee system. The Section has had hearings recently in Topeka, Kansas City, and Wichita for input into the fee structure. The final decision is close, but no definite fee structure has been decided.

Kansas Public Health Centennial in 1985. Special recognition of the event is planned by the Department of Health and Environment. The Kansas Medical Society has offered to devote the June 1985 issue of KANSAS MEDICINE to mark the Society leadership in the development of public health in Kansas.

Local Health Departments. KMS Resolution 84-25 requested improved communication and cooperation between local medical societies and the local health departments. We have asked each local society to jointly sponsor a conference or program with its local health people to discuss programs, problems, and innovative solutions and to do this on an ongoing basis. A conference of local health officers to be sponsored jointly by the Department of Health and Environment and KMS is planned for the future.

Control of Pediculosis, KMS 84-2. The Department of Health and Environment reviewed KSA 65-122 and, at least for the time being, has decided not to change the statute. After consultation with school administrative personnel, local health and department staffs, KDHE decided to also retain the present regulation requiring students to remove nits prior to returning to class after treatment for pediculosis or to be excluded from the classroom as long as nits are found in the hair. This regulation conflicts with the statute and is counter to KMS Resolution 84-2. We will continue to encourage the Department to become enlightened on this issue, but the committee believes it is now time for concerned physicians to go to their local school boards and discuss this issue if there is a problem so that the schools will in turn input this back to Health and Environment to encourage reevaluation.

Environment and Hazardous Waste Disposal. This area has been followed fairly closely in relation to asbestos in hospitals and nursing homes and to waste disposal sites — particularly hazardous waste disposal site legislation. Recent legislation imposes a moratorium on all hazardous waste disposal until a "more adequate" system of control is found.

Kansas Foundation for Medical Care
Louis M. Culp, M.D., Chairman

To say that KFMC's past year has been a busy time would be an understatement. As both purchasers and providers of health care aggressively ex-

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amine ways to maximize efficiency without compromising the quality of health care, the demand for peer review services has increased both in the public and private sectors.

Medicare

Concerned with the impact of prospective payment on the quality and utilization of health care services, Congress passed legislation establishing Peer Review Organizations (PROs).

On June 29, 1984, KFMC contracted with the Health Care Financing Administration to become the Peer Review Organization for Kansas. Since that time the vigorous review program has substantially altered traditional Kansas Medicare review activities. The program continues to expand as all parties including physicians, hospitals, government, and review organizations adjust to the evolving demands.

Private Sector

Last October, KFMC renewed a three-year contract with the Kansas State Department of Social and Rehabilitation Services to conduct concurrent review of all admissions and continued stays for Medicaid/MediKan patients in Kansas hospitals.

Currently KFMC contracts with 13 organizations representing approximately 215,000 Kansas employees and dependents.

Competition

A significant competitive environment has developed in review activity. Numerous insurance companies, third party administrators, and independent cost containment firms have begun their own review programs. Many physicians already have been required to contact a national 800 telephone number to obtain medical necessity certification.

KFMC's preadmission review program is designed to offer a local alternative to the less sensitive, and sometimes less professional, national review programs.

Summary

In summary, KFMC will continue to meet changing demands, keeping in mind the needs of Kansas physicians. There is no doubt that continued physician input and direction are necessary to assure that quality and accessibility of health care are not compromised by efficiency.

KMS President
F. Calvin Bigler, M.D.

This past year has been enjoyable and very busy. In carrying out the business of the Society, your President has traveled 40,000 miles by car and 20,000 miles by plane. I want to thank each of you for helping make this past year so memorable and productive. The response by the membership of the Kansas Medical Society has been overwhelmingly positive. Not once in this past year has my request of any member to assume a significant leadership role or to do a certain task been met with anything but a strongly positive response. I feel honored to have spent this year as your President. It has been fun to have been in this position at this time. I do not feel that I caused any of the accomplishments, but I am happy to have been here to preside over these achievements.

The previous reports have covered the high points of almost all the year's happenings. I want to lift up for emphasis three particular areas. First, a lot has been going on at the Topeka office of the Society. Jerry Slaughter has brought about many positive changes. He has carefully thought out, written down, and presented to the Executive Committee and Council many fine immediate and long range improvements. A computer was added to the office early this calendar year. Data collection and storage, mailing lists, billing, accounting, payroll have all been computerized. Right now the office building is undergoing a major recarpeting and "face lift." I invite all of you to visit the Topeka headquarters any time after June 1 to see the "new look." A new professional has been added to the staff in Topeka and Jerry will introduce her later in the meeting. I want simply to say that after being in close contact with the people who work for the Society in Topeka, I have been impressed with how hard they work, their tremendous qualifications, and the service they provide for each and every member of the Kansas Medical Society through their dedication to improving the health care of the citizens of our State.

The second aspect of this past year deserving emphasis is our very fine journal. KANSAS MEDICINE has undergone major renovations. Dr. David Gray is an outstanding editor and we have an excellent editorial board. Your President made a vigorous attempt to obtain a large grant for the journal. My goal was to find one or more gifts substantial enough such that KANSAS MEDICINE could be annually subsidized by the interest without diminishing the principal. Worth remembering is the fact that the *New England Journal of Medicine* started out as the *Journal of the Massachusetts Medical Society*.

Finally, the report of the Professional Liability Committee has already been given. The passage of the substitute for Senate Bill 110 was a great accomplishment. The reduction in the surcharge for the Health Care Stabilization Fund previously announced at 120% to the just announced 110% has already saved each KMS member more than the cost of the $100 assessment. We are indebted to the tremendous work of Dr. Jimmie Gleason, Wayne Stratton and Jerry Slaughter, as well as many others who accomplished the passage of this bill. Our efforts for tort reform are an absolute necessity as we work for some immediate relief for the malpractice crisis. A legislative interim study committee will be further concerned with tort reform this summer.

However, further reforming the tort system of handling professional liability is like fine-tuning a Model T. In my opinion, the tort system is a capricious rich man's lottery that does not adequately take into consideration the patient who may have, indeed, sustained injury caused by medical care. Many of us are convinced that these medical and surgical injuries must be removed from the tort system and be placed in a system of administrative justice similar to that which governs injuries that occur to the individual in the work place. This would be analogous to the Workers' Compensation Law and would be superior to our hit-or-miss way of taking care of medical accidents. The injured patient would be the center of our concern. Instead of waiting for years for settlement and depending upon the abilities of one or more attorneys to sway the judge and/or the jury, the patient's needs would be addressed, leaving both doctors and lawyers out of the center of the stage. The advantages of such a system are that it would be timely, adequate, universally applicable, would not require that an individual be wealthy to withstand years of waiting for compensation, and it would take care of more people. Kansas is far ahead of any of the other states in working toward such a patient-oriented program. I am happy to announce that as a result of months of work we now have a complete set of statutes for the Medical Accident Compensation Plan. This treatise was authored by Bryce Moore, J.D., the former Workers' Compensation Director. Professor Robert Fowks, M.B.A., J.D., of Washburn University School of Law, was on this subcommittee chaired by M. Martin Halley, M.D., J.D. I encourage each of you to study this definitive answer to the crisis in professional liability. Many of us think that the tort system

is outmoded. Bringing a patient-oriented compensation plan into law is a tremendous challenge. However, I am reminded of the words of the late great William Allen White writing in the *Emporia Gazette:* "Whenever anything good comes to this country, it happens first in Kansas."

Mark your calendars for September 6. On that date in Topeka there will be a seminar addressing a solution to the malpractice crisis by patient-oriented programs. Among other speakers, the originator of such a concept, Sir Owen Woodhouse of New Zealand, and Dr. Richard Smith, Assistant Editor of the *British Medical Journal* from London, who is the foremost medical writer on "no fault" compensation for medical accidents, will be there.

In conclusion, it has been a great year. I want to invite you all as part of the installation ceremony tomorrow evening to some surprise entertainment. I can guarantee it will be a surprise. I hope you find it entertaining. (See below.)

Jerry Slaughter, Executive Director, gave a report dealing primarily with this year's legislative issues.

The Speaker next introduced William J. Reals, M.D., former KMS President and now AMA Delegate, who presented all former KMS Presidents with appropriate medallions denoting their office. Dr. Reals had developed and purchased the medallions as his contribution to the Kansas Medical Society for the financial and political support which he has received during the years as a member of the AMA Council on Medical Education. He presented the traveling medallion to Dr. Bigler as the President in office. Dr. Bigler gratefully acknowledged the gift and called on all former Presidents to step forward to receive their medallions. Those present were: Jimmie A. Gleason, M.D.; Herman W. Hiesterman, M.D.; Warren E. Meyer, M.D.; William J. Reals,

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Warning to KMS Members

If you find the presence of this picture in the state's leading medical journal inexplicable, it proves that (a) you did not attend the annual meeting of the Kansas Medical Society at the Broadmoor in Colorado Springs, and (b) moreover, you haven't talked to anyone who did. In order to understand such esoterica and be identified with the finer aspects of medical life, you are advised to begin planning your attendance at the 1986 meeting in Topeka.

M.D.; Thomas F. Taylor, M.D.; John W. Travis, M.D.; and Kermit G. Wedel, M.D.

Dr. Bigler also thanked all former Presidents for the services that they have rendered and continue to give to the Society.

Under the item of unfinished business, Dr. Stone, Speaker, called the Delegates' attention to the summary of the 1984 resolutions. He stated that all new resolutions contained in the Delegates' notebook are automatically introduced and seconded. The following new resolutions were then introduced:

- Harold W. Collier, M.D., Wichita, Delegate from the Kansas Society of Anesthesiologists, introduced a resolution seeking KMS support in equalizing the inequities of Medicare reimbursement (85-27).
- Donald W. Hatton, M.D., Lawrence, introduced a resolution providing for an annual Jesse Rising Lectureship during the state meeting (85-28).

At this point, Dr. Fransen, Vice Speaker, assumed speakership to allow Dr. Stone to present a resolution:

- G. Rex Stone, M.D., Manhattan, introduced a resolution calling on the Kansas Medical Society to establish a Professional Provider Organization (85-30).

The Speaker announced that the following Council Districts need to elect Councilors for 1985: 2, 4, 11, 13, 14, 15, 17, 19.

The Reference Committee was introduced as follows: Edwin D. Rathbun, M.D., Liberal, Chairman; Stephen F. Miller, M.D., Parsons; Charles S. Reeves, M.D., Fort Scott; Jay S. Schukman, M.D., Great Bend; and Arthur D. Snow, Jr., M.D., Shawnee Mission.

The Speaker announced that Jerry Slaughter, Executive Director, will be the luncheon speaker at the Delegates' luncheon today. He also stated that the next meeting of the House of Delegates will convene on Sunday at 8:30 A.M. He then adjourned the First Session at 11:00 A.M.

SECOND SESSION

The Second Session of the House of Delegates was called to order by the Speaker, G. Rex Stone, M.D., on Sunday, May 5, 1985, at 8:30 A.M., at the Broadmoor, Colorado Springs.

The Speaker announced the presence of a quorum and noted that the Session would be conducted in accordance with *Sturgis Standard Code of Parliamentary Procedure*. He briefly reviewed some rules and announced the following tellers: John H. Rempel, M.D., Wichita, Chairman; Jimmie L. Browning, M.D., Cottonwood Falls; and Clifton C. Schopf, M.D., Wichita.

While the ballots were being distributed, the Speaker called for the results of Council District caucuses. They were as follows:

District #2: Richard Gruendel, M.D., Kansas City, Councilor; Louis M. Culp, M.D., Kansas City, Alternate

District #4: Kent Cooper, M.D., Pittsburg, Councilor; Stephen Miller, M.D., Parsons, Alternate

District #11: Clifton Schopf, M.D., Wichita, Councilor; James Loeffler, M.D., Wichita, Alternate

District #13: Victor M. Eddy, M.D., Hays, Councilor; William Halling, M.D., Hays, Alternate

District #14: Wendale McAllaster, M.D., Great Bend, Councilor; Donald L. Wikoff, M.D., Great Bend, Alternate

District #15: Edwin D. Rathbun, M.D., Liberal, Councilor; Richard L. Nevins, M.D., Liberal, Alternate

District #17: Don Tillotson, M.D., Ulysses, Councilor

District #19: Robert J. Haskins, M.D., Chanute, Councilor; Kenneth L. Knuth, M.D., Independence, Alternate

The results of the election were announced as follows:

PRESIDENT ELECT: Franklin G. Bichlmeier, M.D., Kansas City

FIRST VICE PRESIDENT: Donald W. Hatton, M.D., Lawrence

SECOND VICE PRESIDENT: Terry L. Poling, M.D., Wichita

CONSTITUTIONAL SECRETARY: Richard M. Skibba, M.D., Wichita

TREASURER: Roger D. Warren, M.D., Hanover

AMA DELEGATE 1986-87: Lew W. Purinton, M.D., Wichita

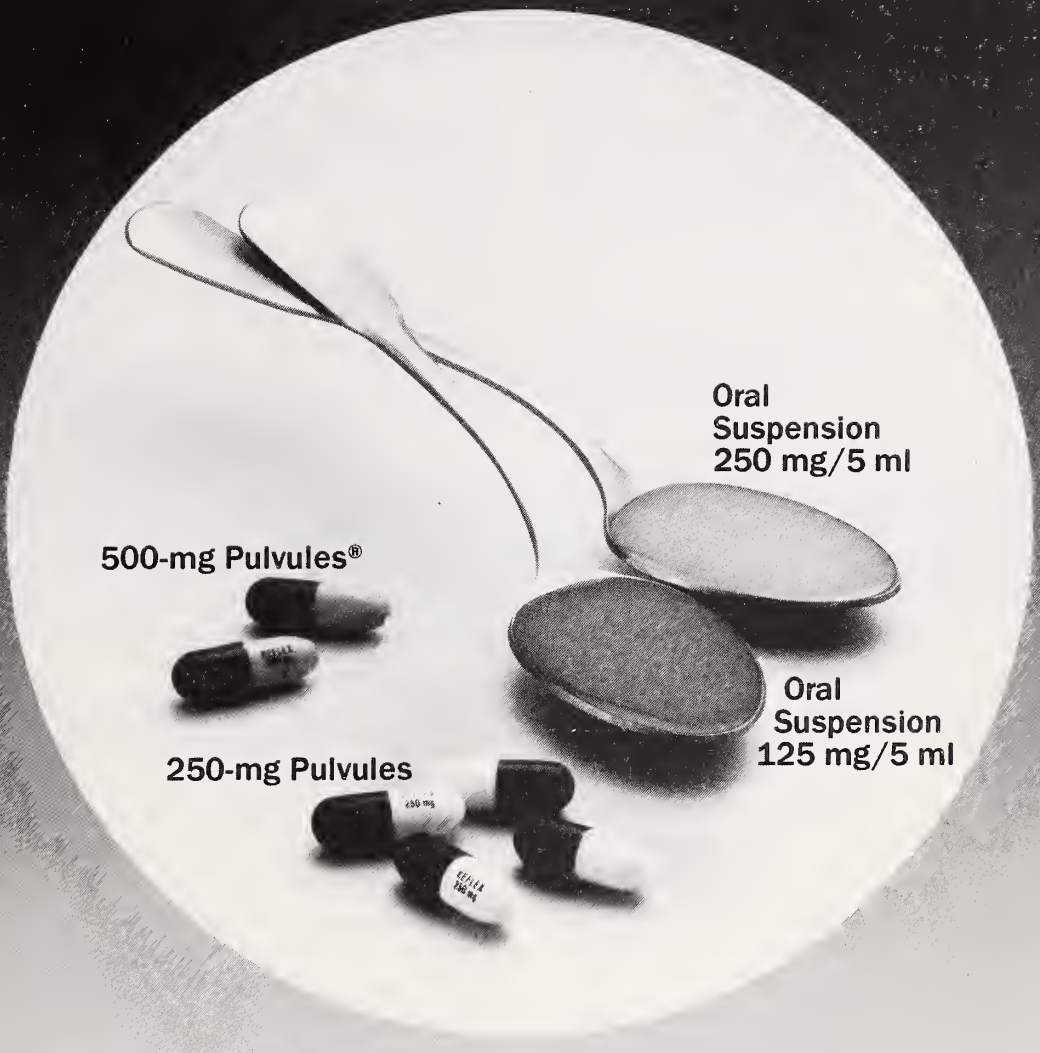
AMA ALTERNATE DELEGATE 1986-87: Jimmie A. Gleason, M.D., Topeka

SPEAKER: G. Rex Stone, M.D., Manhattan

VICE SPEAKER: Edwin D. Rathbun, M.D., Liberal

Edwin D. Rathbun, M.D., Chairman of the Reference Committee, presented the Committee's report and recommendations as they pertained to each resolution. Resolutions 85-14; 85-15; 85-16; 85-25; 85-26; and 85-28 were placed on the Consent Calendar and adopted. The greatest amount of discussion

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centered on Resolution 85-12, Unified Membership, which was adopted almost unanimously, 110 to 5 (please see resolutions in their final form following these minutes). Resolution 85-30, Commendation of the Ford County and Southwest Medical Societies was introduced from the floor and greeted with unanimous approval. The House unanimously acknowledged their pleasure with the meeting arrangements by giving Gary Caruthers a standing ovation.

The Speaker asked for a voice indication of the desirability of holding another meeting at the Broadmoor. The approval was almost unanimous.

The newly elected President, Clair C. Conard, M.D., Dodge City, then installed the Speaker, G. Rex Stone, M.D. and Vice Speaker, Edwin D. Rathbun, M.D. Dr. Conard then made the following remarks:

Malpractice has dominated our attention this past year, and while it will continue to do so, there are other committees that have important activities which must not be overlooked.

The membership committee is involved with retention and recruitment of new members, as well as finding ways to increase the benefits for our members. It is only through strength that we will accomplish our goals.

We must study and develop methods to produce *non*-dues income, so that we won't be limited to a dues increase each time we need to expand or keep up with inflation.

The Healing Arts Board is going to be the subject of an interim study by the Legislature this summer. The legislators perceive the board as frankly ineffectual. They also turn to physicians and ask, "Why don't you doctors police yourselves?" We need to be sure we can honestly answer that we are doing everything possible.

We have all been asked, "Why is there so much malpractice?" My answer is, there isn't. There are a few physicians with multiple suits against them, and we, too, ask why doesn't the Healing Arts Board do something about these unprofessional physicians, because after all, they tarnish us all. But the majority of suits are against the highly trained specialist working with high risk patients. The basic problem is the expectation of the patients. With computers, scanners, joint replacement and heart transplants, the public has come to expect a perfect result from each physician encounter. This is compounded by a plethora of unprincipled attorneys, all too willing to generate a suit. A recent ad on television by a firm of attorneys asked this question, "Have you been in an accident lately? Perhaps you were injured and didn't realize it. Come see us, the first consultation is free!"

It is personally infuriating to me for physicians to be held to such a high level of unobtainable accountability when other segments of society remain relatively untouched. If a physician even suggests that a patient is going to be all right, this is interpreted by the courts as an absolute guarantee. Yet a guarantee of any other kind in other segments of society is strictly limited to that which is specifically spelled out in writing.

A popular phrase is, "The physician knew or should have known." Why, then, is a lawyer not guilty each time he loses a case, because he knew or should have known the case was inadequate. Is a judge not just as guilty when he makes an improper ruling that is reversed by a higher court? "He knew or should have known."

Of special concern are the recent number of suits where the physician is accused of not making the correct diagnosis, or not making it soon enough. I have never signed an agreement, nor even expressed the opinion that I would always be able to make the correct diagnosis, that I would never be wrong, or having made the right diagnosis, would always prescribe the right medicine that would never have undesirable side effects. I resent the court putting me in a defensive position.

I lose patience with physicians who testify in court, after having the entire answer in front of them, and having months or years to study the case before it comes to trial, who then say the attending physician did not exhibit the customary standard of care. It is one thing to, at leisure, treat a case in the manner of a pathological conference, and quite another to have to make snap decisions in the case of an emergency or without knowing the final diagnosis.

We cannot look to jurors or the legal system for relief. Court procedures are stacked against the physician. Absurd awards are made, depending on how clever the trial lawyer is, if he is a good actor, if he can bring tears to the eyes of the jurors. Extreme awards cannot be justified by actual damages; therefore, the courts turn to the concept of pain and suffering, and this is why we must work for limits on pain and suffering awards.

There is nearly total lack of ethics on the part of malpractice lawyers. There was a day when the ultimate insult to lawyers was to refer to them as "ambulance chasers." We have now arrived at the point where probably the most notorious malpractice lawyer in the country proudly proclaimed, "I don't chase ambulances, I'm there before the ambu-

lance.'' The lack of ethics in malpractice law has now become acceptable to the legal profession. This makes it vital that all physicians become politically active. We can no longer afford the luxury of allowing other people to pass laws governing us without our input. We must support KaMPAC and AMPAC and even more importantly, become continually involved in politics at the local level. But all is not despair — look what we have accomplished this year. The elimination of the collateral source rule and restrictions on punitive damages have occurred only because a great many people have become concerned, taken the time to educate the public, and contacted their legislators. We have the task before us of telling our side of the story to the public. Once they realize that they are paying the bill for malpractice premiums and awards, they will start supporting us.

After announcing the meeting of the Council following this Session, and thanking the Reference Committee again for accomplishing their task, the Speaker adjourned the Second Session of the House of Delegates at 10:15 A.M.



Written committee reports begin on page 234; Resolutions on page 243.

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Council District Reports

DISTRICT 3

The practice of medicine has continued to evolve during 1984. The expanding impact of DRGs is being felt both by physicians and hospitals. Hospital admissions and length of stay have declined. More and more procedures are being performed on an outpatient basis.

There are now seven HMOs established in the Kansas City area, some with several sites of operation. PPOs continue to proliferate, with an estimate of 10-12 now in existence; others are still in the planning stages. Hospital operated clinics and practices continue to propagate.

Nearly all Kansas City hospitals have some outside medical endeavor, some with five or more operations that can be identified. These range from hospital sponsored physicians' offices to a wide variety of clinics which include family practice, health maintenance, occupational health, and "mall clinics." In addition, some sponsor visiting nurses, home health care programs, and industrial health programs. Some hospitals have made significant incursions into the surrounding counties with numerous ventures including administration, accounting, computerization, laboratory, EKG, radiology facilities, and similar offerings to establish increased referral patterns.

The Johnson County Medical Society has geared its activities to the metamorphosis of medical practice and the malpractice challenges. Topics of meetings have been the changing environment of medicine, health services in Johnson County, legislative activities, and KaMPAC; several meetings have been devoted to discussion of the professional liability crisis. Through the combined efforts of the medical society and the four county hospitals, a dinner meeting with Johnson County legislators was held in January. Attendance was good — despite adverse weather — and the legislators expressed great interest in the problems presented to them.

The Society continues to grow, with an increase to 377 members from the 1984 level of 369.

The Johnson and Wyandotte County Medical Societies met jointly in September to welcome President Calvin Bigler — the first joint venture in 15 years. There was good attendance and active participation by members of both groups; plans are being made to repeat this cooperative endeavor in 1985.

James G. Bridgens, M.D., *Councilor*

DISTRICT 7

District 7, The Flint Hills Medical Society, is comprised of physicians from a five-county area who meet in Emporia on the first Tuesday of each month. Officers are President, James Geitz; Vice President, Fred Neuer; Secretary-Treasurer, Ralph Neighbor; Program Chairman, Joe Bosiljevac.

Like most physicians, we are concerned about the governmental aspects of medicine and the medical liability crisis. There seems to be a lot of informal and formal discussion about DRGs, HMOs, and PRO review activities.

There have been some changes among our members. Dr. Charles R. Hopper and Dr. J. L. Morgan — a former KMS president — have retired from active practice. Both have chosen to remain in Emporia. Dr. Richard Frazier moved from Emporia to Ohio to further his education in vascular surgery. Dr. Mark Witaczack moved his radiology practice from Emporia to Chanute. Emporia has a new psychiatrist, Dr. Raju, who is affiliated with the Newman Hospital psychiatric unit. Dr. Henry Dick moved from Chanute to Emporia and has joined Dr. Charles Underwood in private practice. Dr. W. Scott Ryan will be leaving Emporia the latter part of May to continue pediatric practice in North Carolina.

In September, the Flint Hills Medical Society and Auxiliary sponsored a nationally known speaker on drug and alcohol abuse. Marsha Keith Schuchard, Ph.D., of Atlanta, Georgia, spoke to a large crowd in Emporia.

The Flint Hills Medical Society and Auxiliary continue to produce and sponsor radio programs on various diseases and health related subjects.

On November 6, we were honored to have Dr. Calvin Bigler, KMS President, as our guest. He reported on current activities of the Society and forecast upcoming problem issues.

In January we voted to donate $500 to the KMS professional liability committee for its efforts on behalf of malpractice legislation. State Representative Jim Lowther was our guest speaker at that meeting.

Litigation between the Board of Education and two local chiropractors apparently has ended in favor of the chiropractors. They sought to change the school board's policy so that chiropractors would be allowed to perform athletic physical examinations. The school board finally dropped the suit due to the



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increasing costs of litigation. The Attorney General's office was unable to issue an opinion — as requested earlier by KMS — because the suit had been filed. Since the suit is no longer in process, it is likely that an opinion can now be obtained.

We are proud of our KMS leaders and staff and appreciate the job they are doing in our behalf.

John P. Brockhouse, M.D., *Councilor*

DISTRICT 8

This has been a quiet year in District 8. The autumn visit from our President, Dr. Calvin Bigler, was well attended. He gave us the highlights of the medical society program with special emphasis on the malpractice problem.

Most physicians in this district contributed to the malpractice fund and most have participated in the legislative process by contacting their representatives and senators. The district's physicians are somewhat disappointed that the final bill, Substitute SB-110, did not contain the factors that we thought were necessary to control the skyrocketing malpractice problem. Our district members will continue to support the legislative effort to reduce this problem, both by donations to the lobbying fund and by personal contact with representatives and senators.

Several members of District 8 are looking forward to the KMS Annual Meeting in Colorado Springs in early May. We hope that the attendance there will justify moving it out of the state.

Newton C. Smith, M.D., *Councilor*

DISTRICT 10

Physicians of District 10 met for dinner on November 27, 1984, at the Elks Lodge in Newton. Approximately 50 physicians and spouses heard President Cal Bigler present an update on the professional liability crisis and other activities in the state.

We have met individually with our state representatives and senators regarding the malpractice problem. It appears that Representative Leroy Fry and Senator Roy Ehrlich are sympathetic with the needs of the patient and the physician and are trying to curb the abuse of the trial lawyers, courts, and insurance companies on this issue.

R. A. Siemens, M.D., *Councilor*

DISTRICT 11

The addition to the Medical Society of Sedgwick County (MSSC) office building has been completed, and everyone is satisfied with the facility. We invite all Kansas physicians to visit our offices.

The MSSC medical referral service continues to serve the public well, although two hospitals in Sedgwick County have their own referral services. MSSC will expand efforts to better serve the community.

The MSSC Medical Careers Loan Fund continues to have more applicants than funding will accommodate. There have been a total of 54 individuals helped since 1960. Of the current nine persons, two were added this year.

The MSSC-sponsored health insurance plan has been in operation for one year, and is meeting the health care needs of physicians. The premium rates and benefits are very competitive with other such plans. Sixty-four physicians' offices are currently enrolled with a total of 375 participants.

The MSSC Foundation continues to operate and has definitely affected hospital admission practice patterns of physicians. The Foundation currently has contracts with Boeing Company "salaried employees," Beech Aircraft Company, Cessna Aircraft Company, Vulcan Chemical Company, and Dillon's. In addition, the MSSC Foundation is subcontracted to KFMC for all Title XIX recipients in Sedgwick County.

The MSSC has formed a separate corporation to develop a PPA known as Wichita Preferred Provider Association. This organization has affected plans to deliver health care to the community, vis-a-vis:

- second surgical opinion
- pre-admission certification
- fee schedules
- utilization review

Industry and business have shown much interest in this concept developed on a community basis, to be started by July 1, 1985.

A cost containment round table continues to meet to make recommendations to be implemented to contain health care costs. This round table was established seven years ago by labor and the MSSC, and it has been expanded to include representatives from hospitals, business, industry, and consumers.

Our legislative committee, which has 25 physician members, meets weekly during the Kansas legislative session. They review bills and make recommendations to legislators both as a group and on an individual basis.

Clifton C. Schopf, M.D., *Councilor*

DISTRICT 12

District 12 is composed of the Tri-County Society and the Ninnescah Society.

The Ninnescah Society (Pratt, Kingman, and Stafford Counties) meets quarterly in Pratt for dinner

and a visiting speaker who addresses medical topics. The osteopathic physicians in this area were invited to our annual meeting with the KMS president last fall.

The Pratt Regional Medical Center is fortunate to be part of a pilot program in which our hospital has a formal agreement with the University of Kansas College of Health Sciences. This agreement, signed on June 15, 1984, provides primarily for the extension of educational services from the University Center to less urban community hospitals such as ours.

Our medical community was saddened during the past year by the tragic shoulder injury sustained by Patrick Barker, M.D., while he was stopped at the scene of an auto accident to render aid. This has kept him from his practice for many months. Roger Mason, M.D., trained in General Surgery and Peripheral Vascular Surgery, has come to help Dr. Barker and carry on his practice. During the year we also welcomed Carl Rosen, M.D., Urologist, and Juliana Reser, M.D., Family Practitioner. Ron Quenzer, M.D., is currently on leave of absence for a year to serve as visiting assistant professor in Internal Medicine on the infectious disease services at the University of New Mexico.

Members of our Society are seriously concerned about the malpractice threat and the changes in Medicare and related hospital utilization, but we are heartened by the efforts and accomplishments of the KMS in the malpractice area.

The Tri-County Medical Society meets six times a year at the Copper Club in Harper. The meeting usually consists of dinner followed by a one-hour CME program. This gives members the opportunity to socialize with each other, and the speakers generally are quite informative.

The major concern in our society this year is the malpractice problem. Most physicians have experienced a doubled insurance premium this past year, which has influenced some of them to give up some surgical or obstetrical practice. There has been some discussion about a community-wide effort to address the problem of obstetrics services, but nothing has been organized to date. Many physicians feel that the medical community needs to inform the public of the need to limit malpractice judgements and physicians' liability, or face the risk of losing availability to obstetric care except in large metropolitan areas.

Carl D. Ambler, M.D., *Councilor*

DISTRICT 16

The Northwest Kansas Medical Society, comprised of the ten counties in the northwest corner of Kansas, has 31 active members at present (a loss of one during the past year) and five emeritus members. The physicians of this area are deeply concerned about the malpractice crisis: two physicians have retired early with high insurance rates being one of the major factors in their decision. One semi-retired physician no longer does locum tenens work for local physicians because of the unreasonable insurance rates. It is likely that some counties in our area will lose obstetrical services within the next year as insurance premiums increase.

The problem of qualifying as a "medically underserved area" has also shown itself to be more political than real. Lack of physicians in an area is not nearly as important as proper communication with a political representative in establishing an area as underserved. We are sure that the practice of medicine will survive, but are not so certain as to the quality of survival.

John R. Neuenschwander, Sr., M.D., *Councilor*

DISTRICT 17

The Southwest Kansas Medical Society held three meetings during 1984, combining social, educational, and business functions. Dr. Gregory Duick presented new trends in cardiology; KMS President Cal Bigler shared concerns from the state society; reports and committee appointments were dealt with, and routine business was conducted.

District 17 is fortunate to have KMS President F. Calvin Bigler as a member. Dr. Bigler has kept us abreast of state and national issues in organized medicine throughout the year. Southwest Kansas Medical Society would like to pay tribute to Cal for his leadership, initiative, and many hours of service to our professional organization.

Max E. Teare, M.D., *Councilor*

DISTRICT 18

Problems in District 18 during the past year have included continued hassles over DRGs; KFMC reviews and requests for *multiple* complete chart copies (54 in one quarter from one hospital); and the influx of HMOs, PPOs and other fourth party infringements on the practice of medicine (*NEJM* 312:579, 1985). KMS needs to address the fourth party question directly to give some in-depth understanding to members in our district *before* they are forced to go one direction or another.

Otherwise, our district is progressing in size and sophistication about on schedule.

David A. Leitch, M.D., *Councilor*

Health Examination for Young Athletes

Arthur Cherry, M.D., *and* Virginia L. Tucker, M.D., *Topeka*

As increased numbers of children and youth of both sexes participate in a widening selection of sports activities, physicians have become more aware of the need for institution of methods for prevention of athletic injuries. The preparticipation examination provides early recognition of interfering medical problems and identification of residuum of previous injuries.

A sports preparticipation history and physical examination form and manual designed to evaluate critical areas of medical concern to the athlete has been approved by the Kansas Medical Society, the Kansas High School Activities Association and the Kansas Association of School Health. For several years it will serve as an optional replacement for the present form.

The preparticipation examination screens the prospective athlete's general good health, identifies treatable medical problems, allows treatment and rehabilitation of previous athletic injuries prior to the first practice session, provides a comparative evaluation of size and maturation, recommends participation in an alternative sport when indicated or sets limits of participation and fulfills both legal and insurance requirements. It is not a substitute for the comprehensive health evaluation or routine health care from the primary care physician.

The complete sports history and physical examination should be initiated at the entrance into school-based cheerleading or competitive sports at least four weeks prior to onset of practice and again upon entrance to senior high or transfer from out-of-state into a Kansas school. The history will be updated annually four weeks prior to onset of practice to identify medical problems or athletic injuries having occurred during the previous year. If any questions are answered "yes," referral to an appropriate medical consultant and permission of medical release must be completed prior to entrance into any phase of the sport.

The new forms may be obtained from the Kansas High School Activities Association by the school district administrators to distribute to coaches and school nurses. A manual will be available in the fall or when printing is completed.

A professional training program is being developed which includes a film demonstration of a successful preparticipation examination program existent in the Olathe High School directed by Dr. Kieth Sheffer, and a workshop to demonstrate specific points related to the examination and to answer questions. As soon as these materials are ready for presentation and the manual printed, Kansas primary care providers will be informed of their availability.

For further information, contact Virginia L. Tucker, M.D., F.A.A.P., Medical Consultant for School Health, Forbes Field, Bldg. #730, Kansas Dept. of Health & Environment, Topeka KS 66620.

SCIENTIFIC ARTICLES

Pregnancy With IUD *in situ*

John H. Fallon, M.D.,* ***Indianapolis, Indiana***

The intrauterine contraceptive device (IUD) is one of the most popular methods of nonpermanent birth control. Although in concept it has existed since ancient times, alterations and refinements in the past 20 years have boosted its efficacy and hence its popularity. Patients elect an IUD because it is an effective means of birth control, it requires little attention after initial placement, it has a relatively low complication rate (lower in fact than present birth control pills), it is unrelated in its use to the time of sexual intercourse, and it is inexpensive. In addition, its side effects are generally localized; it lacks hormonal — hence systemic — complications.

It is estimated that more than 15 million women are currently using IUDs; if it is assumed that the failure rate of the typical IUD is approximately 2-3%, then 300,000 to 450,000 pregnancies can be expected. Although it is possible to develop IUDs with near zero pregnancy rates, such IUDs are associated with high rates of removal for pain and bleeding. There is little hope of developing IUDs with zero failure rates and acceptable rates of expulsion or removal for pain or bleeding until the mechanisms of how the IUD prevents birth are more clearly understood.

The continuing problem that confronts physicians, then, is how to handle the 2-3% of patients in whom pregnancy occurs. Removal of the IUD can often entail probing of the uterus and traction on the device, both potentially traumatic to the mother and her pregnancy. Leaving the device in place, however, places the woman at risk for spontaneous abortion and septic complications. Some women may elect to have their pregnancies terminated by therapeutic abortion; others will elect to carry their pregnancies to term. The pregnant woman facing this choice must rely upon her physician to advise her of her potential for a term pregnancy and the possible complications — both to the mother and fetus — that may be caused by the presence of an IUD. Ultimately, if the woman wishes to maintain her pregnancy, the physician is faced with the decision of whether or not the IUD should be removed.

Localization of the IUD is an important first step in care. Sometimes the pregnancy is not the result of IUD failure but of IUD extrusion. Ultrasonography is the method of choice for locating an IUD when the string is not visible in the vagina. Occasionally the IUD string is not seen because it has been drawn up into an enlarging pregnant uterus. In most cases, the IUD is in the endometrial cavity and the string has been drawn up alongside it. Longitudinal and transverse pelvic sonograms will generally show the device if it is *in situ*. The advantage of ultrasound is that it provides a three dimensional view; X-ray examination cannot show an IUD in the plane of the endometrium unless dye or instruments are introduced transcervically. In addition, radiation to the developing fetus is potentially teratogenic.

Generally, when pregnancy occurs with an IUD in place, implantation occurs away from the device. Because of this, the device remains extraamniotic. Ultrasonography can show both the IUD and the gestational sac.

If the IUD is left in place, the woman is at increased risk for abortion. In 1970, in some of the earliest work done on the topic, Lewit[1] studied IUD pregnancies among 722 women and found an abortion rate of almost 50% if the IUD remained *in situ*. The devices were subdivided into tailed and tailless categories. Tailed IUDs (such as loops) yielded a slightly higher abortion rate, but their removal greatly improved the chance for live birth. Tailless devices, in order to be removed, require insertion into the uterus of an instrument with which the IUD is hooked and extracted. For tailless devices, the abortion rate after manipulation was more than that prior to manipulation.

In 1973, Alvior[2] studied 201 women; the IUD was removed if three criteria were satisfied: the pregnancy was in the first trimester, the thread was visible, and the IUD offered no resistance when pulled. Of

(Continued on page 253)

* General surgical resident, Methodist Hospital, Indianapolis, Indiana.

Address reprint requests to Dr. Fallon, Dept. of Surgery, Methodist Hospital, 1640 Capitol, Indianapolis IN 46202.

PRESIDENT'S MESSAGE

The House of Delegates took a bold progressive step in Colorado Springs. They voted, nearly unanimously, to make Kansas a unified state as far as membership is concerned. This means that all members of the Kansas Medical Society will be members at three levels: The county medical society, Kansas Medical Society, and the American Medical Association.

The discussion was most interesting. Some of the older physicians expressed concern about the additional cost of dues for the younger physicians; but it was the younger physicians who perceived the need for a strong AMA to represent them.

An argument that always arises is, "I don't want to be forced to join any organization." It is a familiar argument because I used to say the same thing. But on examination, it is flawed logic. Almost every organization that I belong to, or can think of, is a unified organization: Boy Scouts, Rotary, Kiwanis, Masonic Lodge, Knights of Columbus, etc. Membership at the local level automatically means affiliation at all levels. This we accept without a second thought. But paradoxically, when we talk about our profession and the organizations that are vital to us, we suddenly bring up the issue of mandatory membership.

Occasionally, one also hears as argument, "The AMA doesn't represent me," meaning that on certain issues we don't agree with the AMA's position. If we withdrew from every organization, every association, every personal relationship because we don't agree with *all* of their actions, what, or who, would be left?



If the AMA doesn't represent us, then we are without representation. Yes, we all have specialty organizations, but none represent more than a few thousand of us with special interests.

Our opponents, government regulators, etc. would like nothing more than for medicine to be divided into smaller, vulnerable groups. If we physicians get our act together and remember our priorities, we can accomplish a great deal. Strength through unified membership is an important first step.

E. E. Leonard, M.D.

President

KMS

Kansas Medical Society Newsletter

JULY 1985

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MALPRACTICE:LEGISLATURE BEGINS SUMMER STUDY

In what promises to be the most comprehensive study ever conducted in Kansas on the malpractice problem, a 21 member legislative committee began hearings July 1 and 2. The committee has meetings scheduled every month through November. It is expected that several recommendations for reform will be forwarded to the full legislature as a result of the committee's deliberations.

At the first meeting the committee held two days of intensive hearings on the background of the problem, the current environment, and what the future may hold. KMS testified, recommending the following reforms for consideration:

1. Limiting awards in malpractice lawsuits.
2. Limiting contingent fees.
3. Requiring itemization of awards.
4. Restructuring screening panels to weed out frivolous claims.
5. Mandatory use of structured settlements.

The next two meetings of the committee, scheduled for July 17 and 18 will deal with the insurance industry, the operation of the Health Care Stabilization Fund, and the function and performance of the Healing Arts Board as it relates to disciplining physicians.

The Special Committee on Medical Malpractice is chaired by Representative Joe Knopp (R-Manhattan); and the Vice Chairman is Senator Jack Walker, M.D. (R-Overland Park). Other members of the panel are:

REPRESENTATIVES	SENATORS
Joe Knopp, R-Manhattan	Jack Walker, R-Overland Park
Marvin Barkis, D-Louisburg	Roy Ehrlich, R-Hoisington
Bill Brady, D-Parsons	Paul Feleciano, D-Wichita
Frank Buehler, R-Claflin	Frank Gaines, D-Augusta
Rex Hoy, R-Shawnee Mission	Jeanne Hoferer, R-Topeka
Ruth Luzzati, D-Wichita	Nancy Parrish, D-Topeka
Mike O'Neal, R-Hutchinson	Jack Steineger, D-Kansas City
Vincent Snowbarger, R-Olathe	Robert Talkington, R-Iola
John Solbach, D-Lawrence	Wint Winter, R-Lawrence
Dale Sprague, R-McPherson	Eric Yost, R-Wichita
Tom Walker, R-Newton	

KMS is in the process of updating data on the problem and will be sending a packet of background information to the membership in the coming weeks. Please watch your mail for details, and stay in touch with your legislators.

In This Issue...

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- Midwest Regional Conference on Women in Medicine
- DRGs
- CPT-4 Reporting Problems
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- Choice Care

UNIFIED MEMBERSHIP

As reported in June, KMS House of Delegates, by a nearly una mous vote, decided to implement unified local-state-AMA mem ship (for details of this action please refer to this July issue of KANSAS MEDICINE). Also by an overwhelming majorit members of the Mississippi State Medical Association House Delegates voted to unify its membership with AMA effective 1, 1986.

The AMA House of Delegates last month adopted the Kansas re lution authorizing dues increase exemption for Kansas and Mississippi. Therefore, AMA dues for 1986 remain unchanged these states. In addition, states with unified membership receive a 10% discount. This means that the 1986 AMA dues be $297.

Other states are studying the unification issue, notably California, Connecticut, Michigan, Missouri, North Dakota, South Carolina, Virginia and Wyoming. There is a growing pe ception among physicians nationwide that a strong national umbrella organization is needed to press for solutions to problems affecting medicine as a whole. Such an organizatio is needed to aggressively meet the challenges ahead; work w health policy-makers to protect the integrity of health care address the changing consumer needs and demands; develop via solutions to cost problems, and counter the myriad forces threatening to lessen the quality of care.

As physicians face decisions and pressures of unprecedented complexity, the words of President Teddy Roosevelt bear repeating: "Every man owes a part of his time and money to t business or industry in which he is engaged. No man has a mo right to withhold his support from an organization that is striving to improve conditions within his sphere."

REALS RE-ELECTED

William J. Reals, M.D., Dean, UKSM-Wichita, has been re-elec to the Council on Medical Education of the American Medical Association. First elected in 1981, Dr. Reals was elected three year term during the AMA House of Delegates Meeting on June 19 in Chicago. The council, comprised of 12 physicians staff is concerned with matters of medical education and adv ses the AMA on major policy issues.

ALZHEIMER'S DISEASE

The 1985 Kansas Legislature created the Kansas Alzheimer's a Related Diseases Task Force with the following responsibilit

- -determine incidents, problems and mortality associated with Alzheimer's disease and related disorders in Kansas;
- -identify health and social resources available to the vic tims of the disease and barriers to effective treatments;
- -examine problems faced by victims of Alzheimer's disease and related disorders and their families;
- -recommend policy and a strategic course of action to the 1986 Kansas Legislature.

Among those appointed as task force members are Norbert W. Kearns, M.D., Topeka; D. Cramer Reed, M.D., Wichita; and Lau K. Welch, M.D., Wichita. The advisory council members inclu Alex Scott, M.D., Junction City and Val Braun, KMS staff.

At the national level legislation has been proposed that would substantially increase funding for research into the causes, prevention and treatment of A.D. If passed the Comprehensive Alzheimer's Assistance Research and Education Act (CARE) would establish a national educational program; create model state programs to educate the public; increase the training of health care professionals to improve the diagnosis, treatment and management of the disease; and develop methods of service delivery that will encourage care in the home yet reduce the stress on families of patients.

EDICAL RECORDS

Under what circumstances may a physician refuse to provide this information? The only instance in which a physician may refuse to provide a patient with access to his/her medical record is when the physician "reasonably determines that the information is detrimental to the physical or mental health of the patient or is likely to cause the patient to harm himself or another." In such instances, the physician must supply the information requested to a third party or another health care provider designated by the patient. This person may, in turn, release the requested information to the patient.

HYSICIAN DIRECTORY

Have you introduced yourself to your peers? Call or write the KMS office for details on the new physician directory listings now available in KANSAS MEDICINE.

RACTICE MANAGEMENT

Today's patient expects more of you and your office staff. To help you determine what this new patient needs and wants KMS will be presenting a brief course for physicians on practice building on October 30 at 6:30 p.m. in Kansas City. A workshop designed for medical office personnel will be given on October 31 at 9:00 a.m. Please reserve time on your calendar and watch your mail for details.

985 ROSTER

The August issue of KANSAS MEDICINE will include the annual membership roster. EACH KMS MEMBER WILL RECEIVE ONE COPY. Additional copies will be availble to members at $12 per copy. Non-members may purchase them for $25 each.

OMEN IN MEDICINE

The Second Midwest Regional Conference on Women in Medicine is being planned for September 27-29, 1985 in Kansas City. The conference is open to all physicians and medical students with a focus on the role of women in medicine and with how they can work together with others in all facets of medicine practice. For further information, please contact Lillian Gonzalez-Pardo, M.D., Associate Professor, Department of Pediatrics and Neurology, UKMC, Kansas City, KS 66103, tel. 913-588-4488.

DRGs

Now that hospitals are being paid prospectively for services based on diagnosis-related groups (DRGs), your hospital is likely to - if it hasn't already - establish physician profiles These compilations of data show each physician's usual treatment of a specific type of case, so it is important to work closely with the person or committee in your hospital that's in charge of drawing up physician profiles to insure accuracy. In addition, you may want to consider doing more pre-admission testing to eliminate extra hospital days for your patients. But first, find out which of your regular procedures MEDICARE approves as inpatient admissions and which must be done on an outpatient basis. The above tips should help your patients and hospital obtain appropriate reimbursement for MEDICARE-covered services as well as preserve your right to order essential tests and other ancillary services.

REPORTING PROBLEMS
CPT-4

A growing number of complaints from physicians regarding difficulties with Medicare carriers' refusal to accept claims for CPT-reported services has prompted the Health Care Financing Administration (HCFA) to issue a directive to its regional directors. This directive clarifies the limitations on "editing" of CPT-4 codes, and should soon be implemented by all carriers. Should problems continue, a copy of the directive may be obtained from the KMS office to use in discussion with the carrier. If discussion fails to resolve the problem, contact William M. Cohan of the AMA staff (312-645-4720) who will pursue the matter with HCFA.

MARKET AREA PROFILE SERVICE

The AMA has introduced a new product, the Market Area Profile (MAP) Service, designed to assist physicians with medical practice site selection and development. It offers the first and only source of integrated demographic, physician, and hospital data for any area of the country. Each customized MAP report package includes six informational reports that provide a demographic profile of population, current year estimates and five-year projections of key demographic variables, and current profile data on local physicians and hospitals. For further information, contact Phyllis Kopriva at the AMA, 312-645-4719.

CHOICE CARE

CHOICE CARE is a new product line to be offered through Blue Cross/Blue Shield as an alternative to traditional insurance. As with traditional insurance, it allows the subscriber to select his/her provider, but there is an economic incentive to choose the Choice Care provider. Requests for proposals have been sent to hospitals in Topeka and Wichita requesting fixed competitive DRG bids.

Choice Care physicians must be CAP contracting providers, must submit an application for Choice Care, and must conform to utilization review profiles used by BC/BS.

BC/BS will withhold 15% of fees in a physician risk fund until the end of the year. If expenses exceed income, the fund would be used to offset losses; if income exceeds expenses, the 15% is returned to physicians in proportion to contributions. Maximum risk for a physician is 15%.

Rates would be 10-20% lower than traditional rates and be competitive with PPOs and HMOs with benefits similar to HMOs.

EDITORIAL COMMENT

Increasing Supply or Decreasing Demand?

Even casual attention to the problems confronting the profession's concepts of medical practice leads to the realization that there is an interrelationship — even interdependence — which in itself is one of the threats to cohesive medical action against the whole. Attention is easily diverted from one problem to another to another with the fear on the part of many that nothing of substance can be accomplished. This nihilistic attitude is, in itself, the greatest threat of all as it turns some physicians away from organized medicine, the very place they are needed.

Comes now an editorial in the May 17 JAMA by a Columbia University economist, Eli Ginzberg, whose long observation of medical economics places the problem of the increasing physician supply as the prime concern in the matter. On reflection, it can be seen to have both a cause and effect relationship. If there is not an actual excess at the moment, there is the potential for one as new practice methods evolve. This chicken-egg relationship produces the sense that medical practice in what we have considered the traditional form may well become unrecognizable. The mechanics of adaptation already at work are influencing and influenced by the social currents enveloping all of us.

The question of an oversupply of physicians is no new arrival on the scene. From the beginning some years ago, it has been questioned, firmly denied, firmly supported, deeply feared or strongly welcomed, depending upon the observer's personal attitude and position.

The profession (not blind, but its attention focused more on the traditional concepts of medical practice) has viewed the elephant of excess supply from the side that saw it as productive of deterioration of service and an unhealthy competition rising from economic rather than professional factors. (The fear, however, that the reduction of practice opportunities and purpose would result in a dissuasion of new recruits seems countered by the fact that many young physicians have, in fact, sought practices formerly thought less attractive. On the other hand, the efforts of organized medicine to promote this interest cannot be overlooked.) Although efforts to reduce the medical census have not led to plowing under any of the emerging crops, it has been putting some fields out of production by reducing medical school admissions as well as imposing some restrictions on foreign medical graduates.

Understandably (although perhaps misguidedly), many lay observers have welcomed the prospect of an excessive number of physicians for diametrically opposed reasons: it would force physicians into areas of greater medical need rather than catering to the physician's preference, force medical practice forms of benefit to the patient, stimulate medical service while reducing cost, and produce a healthy competiton comparable to the presumably desirable condition in the market place. Moreover, any reduction in physician income was long overdue and it was time for a general medical comeuppance.

Whatever the conflicts between the public's economic interpretations and the professional interpretations, simple overproduction has not been the only factor in the threat of excessive supply. If, indeed, it were only a matter of increased numbers, we could count noses and reduce accordingly by one process or another to maintain the status quo (as has been the more publicized approach). It happens, however, that — whether cause or effect — the current physician supply is a product of several areas of medical upheaval.

Medical mores are changing. Ancillary personnel, formerly firmly under physician control, are moving toward independence with public approval. More physicians forsake independent practice for some group arrangement (some hospital based, some not, some combining the two). As interdependence of physicians (both for improvement in patient coverage and increase of individual physician free time) is extended, as the generalist-specialist conduit shifts, the old order may indeed be all but unrecognizable.

The benefits of the new order, whether related to excessive physician supply or decreased demand or neither, will be determined, as they always have, by the public's view of need. — *D.E.G.*



COMMITTEE REPORTS

Thomas Taylor, M.D., Chairman, submitted the following report of the *Ad Hoc Committee to Study the Kansas Foundation for Medical Care:*

Recommendations:

1. That the by-laws be amended to include the KMS President Elect, First Vice President, Second Vice President, and one other person from the Executive Committee as full voting members of the KFMC Board.
2. That the KFMC corporate body conduct its annual meeting in conjunction with the KMS annual meeting.
3. That KMS and KFMC establish a regular ongoing staff liaison.

The following items were identified as areas for further review:

1. The need for better information on the review process.
2. Improvement of communications between the attending physician and the reviewing physician.
3. The lack of documentation in physicians' medical records.
4. The hospital reviewer or the KFMC reviewer should notify the attending physician that his/her records are being reviewed.
5. Recommend adequate timely notification to the attending physician for reconsideration hearings.
6. Charge the medical staff committee to hear complaints and continue liaison with the KFMC.
7. There is a need for improved public relations efforts.
8. Include appropriate KFMC information in the KMS *Journal* and *Newsletter*.
9. Recommend joint meetings of the KMS Executive Committee and the KFMC Executive Committee to discuss policy matters.

Richard M. Skibba, M.D., Chairman, advised that the report of the committee on *Constitution and By-Laws* was embodied in Resolutions #85-13 and #85-14.

Donald Hatton, M.D., Chairman, submitted the following report of the *Continuing Medical Education Committee:*

The Continuing Medical Education Committee has been actively involved in surveying and accrediting hospitals and organizations in Kansas for Category I credit. There are currently 26 organizations accredited in Kansas. Twenty-three were accredited by the CME Committee. Three organizations were accredited nationally by the ACCME.

Members of the committee attended the AMA-CME meeting in Chicago in October. Kansas continues to play a prominent role in CME nationally. Several members have participated in the survey and accreditation of national organizations for the ACCME. The Kansas Medical Society will be resurveyed by the ACCME in 1986 to determine whether its accreditation authority will be continued.

Wayne O. Wallace, Jr., M.D., Chairman, submitted the following report of the *Drug Utilization Review Committee:*

A joint program of KMS and the Kansas Pharmacy Association was established in 1978 to improve the quality of patient care through education of the providers.

The program has proven to be a particularly successful means of improving the quality of health care to the Medicaid/MediKan patient by identifying physician and/or pharmacy shoppers, reductions in usage of certain drugs that are subject to abuse; changes in drug therapy, and other cost containment methods.

The widespread cooperation and interest by both the physicians and pharmacists are responsible for the success of the Kansas program, which was one of the pioneers in drug utilization review.

Franklin G. Bichlmeier, M.D., Chairman, submitted the following report of the *Governmental Affairs Committee:*

The Committee has established a close working relationship and liaison with various governmental agencies, notably the Department of Health and Environment, Department of Social and Rehabilitation Services, and the Department on Aging. Because of the complexity and the scope of issues, the work of this Committee was delegated to subcommittees as follows:

Aging — Alex Scott, M.D., Chairman. The primary function here is to provide liaison to the Kansas Department on Aging and to be available to the various agencies and groups on matters of health care delivery to the elderly population. Much activity has been generated in the area of establishing liaison with various groups, such as AARP, KCOA

(Kansas Coalition on Aging), KU Gerontology Center and others. Staffing was provided for the Doctor-of-the-Day Room during the 1984 Silver-Haired Legislature; facilitated dialogue between local medical societies and agencies on aging; as well as direct contact between KMS Auxiliary and KDOA; participated in planning the 1985 Governor's Conference on Aging; gave wide distribution to the Joint Statement on Long Term Care and the Patient Information Brochures.

The 1985 series of KMS Forums on Aging was co-sponsored by the state Department on Aging, Sylvia Hougland, Secretary. The program is geared toward informing the area elderly and their families of ways to reduce expenses for health care and yet maintain an adequate level of care, and represents one of the few direct public relations projects of this society. The local Auxiliary chapters serve as hostesses. The KMS Executive Office plans the program and obtains the speakers; prepares news releases, meeting announcements, agenda and evaluation sheet. Local legislators are included on the program to apprise them of KMS efforts and involvement in consumer affairs. A local physician is also included. 1985 locations, sponsoring auxiliaries and participating physicians were as follows:

Emporia	Flint Hills Auxiliary Paula Neuer (Fred) President	Thomas P. Butcher, M.D.
Hays	Central Kansas Auxiliary Sharon Richards (Dallas) President	Harry E. Watts, M.D.
Lawrence	Douglas County Auxiliary Lori Myrick (Steven) President	Donald W. Hatton, M.D.
Topeka	Shawnee County Auxiliary Sherry Hiszcynskyj (Roman) President	Wm. R. Lentz, M.D.
Wichita	Sedgwick County Auxiliary Mickie Brown (David) President	Norton L. Francis, M.D.

The 1984 series on the subject of communications had served as a catalyst for auxiliary chapters in many areas to develop local ongoing projects of service to the elderly population in the community.

Credentialing — D. W. Bell, M.D., Chairman. The subcommittee reviewed applications for state credentialing for certain allied health groups and defined the following criteria: 1. If the group was not credentialed, did they present a sufficient risk to the public that could be controlled by credentialing? 2. If the group or groups presented sufficient problems that the public needed to be protected because they would not be able to perceive a risk themselves, then credentialing should be supported.

On the basis of these criteria, the Committee recommends as follows:



DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (IV) **for Anxiety** (lorazepam)

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

HOW SUPPLIED: 0.5, 1.0 and 2.0mg tablets.

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Only Ativan® (lorazepam) C IV

offers all these benefits in addition to rapid relief of anxiety:

relief of anxiety associated with depressive symptoms

clearance not significantly delayed by age, liver or kidney dysfunction

cumulative sedative effects seldom a problem

little likelihood of drug interaction
(all benzodiazepines produce additive effects when taken with alcohol or other CNS depressants)

no significant changes in vital signs in cardiovascular patients*

short duration of action, simple metabolism

*Benzodiazepines have not been shown to be of benefit in treating the cardiovascular component.

See important information on preceding page.

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- *Emergency Medical Services Defibrillation Project:* Approved one-year pilot study of the EMT-Defibrillation Program, subject to a number of conditions. The Committee's survey of local medical societies regarding this issue produced a predominantly favorable response.
- *The Opticians' Association of Kansas* is seeking licensing to increase the educational qualifications of dispensing opticians and to allow them independent fitting of contact lenses. It is their hope that they will be included under the Board of Healing Arts rather than the Board of Optometry. The Committee's recommendation is to retain the current system under which the opticians can continue to perform the technical procedures of fitting lenses on instructions of ophthalmologists or optometrists.
- *Master Level Psychologists* did not demonstrate adequate risks to the general public to require credentialing at this time.

The application from the professional counselors is pending before the State Health Coordinating Council (SHCC). According to the present SHCC schedule, this application and one from the Kansas Dietetic Association (reviewed by this committee in 1984) will be presented for legislative consideration in 1986. Following in 1987 will be the opticians, clinical laboratory professionals and the family and marriage counselors.

Richard Meidinger, M.D., Chairman, submitted a report in which he noted that the *Committee on Health and Environment* has continued active dialogue with Secretary Barbara Sabol and Joseph G. Hollowell, Jr., M.D., Director of Health, by addressing the following issues:

- *Kansas Hospital Regulations* are being updated. KMS solicited comments from specialty sections, pertinent KMS committees, local medical societies and appropriate individual physicians. Projected date of completion and availability of the revised document is still targeted for 1985.
- *Health Facilities Study* is a new five-year program under SHCC, designed to benefit local, state and

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federal governments and private industry in planning adequate health care delivery systems. Facilities such as acute care hospitals, adult health care homes, ambulatory surgical centers, psychiatric hospitals, kidney dialysis treatment centers, alcoholic treatment centers, rest homes, etc. will be surveyed to establish standards regarding renovation needs, service gaps, excess capacity, access problems. These standards will serve merely as guidelines and will not be enforceable.

- *Head Injuries* and the need for facilities and stricter laws.
- *Radiation Equipment Fees*. The Department has begun to implement the 1983 legislative authorization to collect registration fees for radiation equipment. Strong opposition to this practice has been registered.
- *Kansas Public Health Centennial in 1985*. Special recognition of the event is planned by the Department. KMS will devote the June 1985 issue of KANSAS MEDICINE to mark the development of public health in Kansas and KMS role in it.
- *Local Health Departments*. Distributed to local/component medical societies KMS resolution 84-25 and received a number of positive comments. A conference for local health officers to be jointly sponsored by the Department and KMS is planned for the future.
- *Control of Pediculosis — KMS 84-2*. The Department is currently reviewing the applicable administrative regulation to bring it into compliance with KSA 65-122.
- *Environment*. Discussions ranged from asbestos in hospitals and nursing homes to waste disposal sites, water quality, etc.

Phillip A. Godwin, M.D., Chairman, submitted the following report of the committee on *Social and Rehabilitation Services:*

- *Primary Care Network,* a medical care delivery system based on the gatekeeper concept, was piloted in three counties. The program is currently under review. It is anticipated that the concept will find applicability in urban areas. SRS solicits proposals for any cost containment formula of health care delivery.
- *Outpatient Services*. The Department has increased reimbursement for selected procedures that have customarily been done in the hospital but that lend themselves to being performed on an outpatient basis. SRS is cooperating in expanding the number of these procedures.
- *Prescriptions*. SRS had considered discontinuation of payment for all drugs to the SRS adult population and to utilize the savings to increase cash grants. This idea was abandoned.

  The Department will again introduce a bill calling for generic substitution for all prescribed drugs for the adult SRS population. SRS agreed to a waiver to allow for specific instances where drug substitution is not workable. SRS wants legislation that will allow reimbursement for any prescriptions equal to the cost of generic drug levels. Under such formula, the pharmacists and the dispensing physicians will be expected to absorb the cost differential on those prescriptions specifying brand name drugs.
- *Rationing of Medical Services*. A joint study of this subject has been proposed to be undertaken by SRS, KMS, KHA, and clergy.
- *Elective Surgery*. The Committee considered the term "elective surgery" for its clarity in denoting medical necessity for a surgical procedure. The KMS members on the Committee failed to perceive any problem with this term. The fact that only a negligible number of surgical procedures (fewer than 15) have been questioned by EDS-Federal during 1984 indicates a general understanding of the term. Moreover, a change in the computer system would require a complete re-education process of physicians over the state, as well as staff, creating a potential for much confusion.
- *Physician Recertification*. Joint efforts have produced a reduction in requirements of ICF recertification from the arbitrary 60-day requirement to 60 days, 180 days, 12 months, 18 months, 24 months, and then every 12 months thereafter.
- *Referred Lab Work*. Federal regulations preclude state agencies from reimbursing physicians for outside laboratory work. This subject will be further discussed in an upcoming meeting with the Department.
- *Baby Doe Legislation*. Both KMS and SRS are monitoring closely the federal guidelines in this area.
- *SRS Medical Care Advisory Committee*. The terms of service of Drs. Theodore E. Young and Dean T. Collins have expired. The Committee nominated Drs. Stuart C. Averill and Ben Rubin, Jr. as replacements.
- *Freedom of Choice Under Medicaid — KMS 84-33*. KMS Resolution 84-33 was not adopted, but referred to the SRS Subcommittee for study and recommendations.

The Resolution was directed at the SRS Primary Care Network (PCN) program, a "gatekeeper" concept of delivery of care to Medicaid patients. It specified that the following four medical specialties be considered as primary care physicians for purposes of assigning PCN clients: pediatrics, internal medicine, family practice, and obstetrics/gynecology.

The review of the PCN study by the SRS Subcommittee revealed the following client assignment process:

1. PCN-enrolled physicians (four specialties) were sent a list of all PCN clients who have seen them at least once during the previous year. The physicians returned the list to EDS/Federal, specifying those clients they wish to retain as patients. Names were assigned on a first come, first serve basis in cases where more than one physician selected the same client;

2. Those clients not selected by a physician were assigned by computer, based on client's location, age, and sex. The attempt to prevent mismatches did not work in all cases. Finally, the computer assigned persons in the same Medicaid group to a single physician unless some family members were already chosen by a different doctor.

3. After the initial selection process by physicians, the clients were informed of their physician assignment and each member of the household was given an opportunity to make an alternate selection from the list of participating PCN physicians. About one-half of the initial assignments were changed on that basis.

4. Those physicians who were late signing up as PCN participants were unable to select their former patients since these had been assigned to the physicians initially participating in the program.

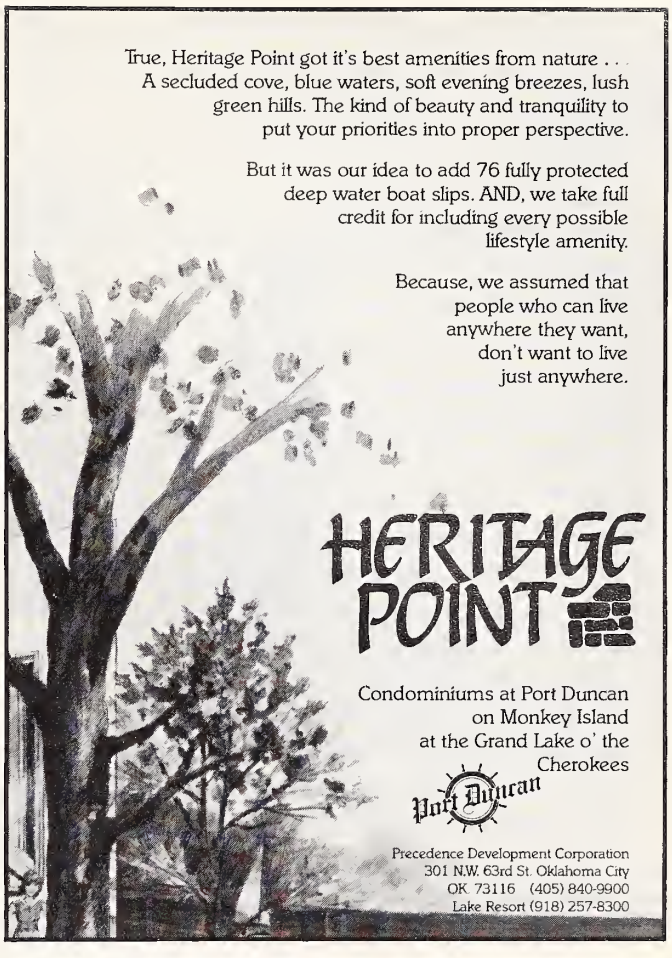
It is the opinion of the Committee that the initial concerns which had prompted Resolution No. 84-33 have been addressed and resolved by SRS.

Warren Meyer, M.D., Chairman, submitted the following report from the *Medical Staff Section:*

The first annual meeting was held March 16, 1985 in Topeka with 36 members and two speakers in attendance. It was primarily an explanatory meeting with good interest and participation by members. A report on incorporation of Medical Staffs was given by Doctor Darr.

Election of Officers:

President: Dr. Terry Poling, Wichita
Vice President: Dr. Richard Darr, Shawnee Mission
Secretary: Dr. D. Cramer Reed, Wichita
Delegate: Dr. Dennis Kepka, Hutchinson
Alternate Delegate: Dr. Charles Reeves, Fort Scott



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Ferris Pitts, MD, University of Southern California, Los Angeles
James Allen Schoenberger, MD, Rush-Presbyterian-St. Luke's Medical Center, Chicago
Menashe Waxman, MD, University of Toronto, Ontario, Canada

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Twelve resolutions were sent to the KMS House of Delegates 1985 meeting. Duties added to KMS HMSS:

1. Liaison with Kansas Hospital Association. Meeting planned to discuss credentialing, CMCHS concerns, Blue Cross Differential Payment System, conflict resolution, and QA & Peer Review for hospital sponsored programs.

2. Liaison with Kansas Foundation for Medical Care for PRO regulation, improvement of communications between physician reviewer and attending physician, and dissemination of information about "care" for less than 24 hours.

3. Plan seminars on credentialing, quality assurance, Medical Staff By-Laws, DRGs, PROs, cost containment, various topics from JCAH, and risk management.

Ivan E. Rhodes, M.D., Chairman, submitted the following report from the *KMS Committee for Impaired Physicians:*

It was assumed that this Committee was most directly affected by the new state reporting laws. We are encouraged to have the assurances of the Healing Arts Board Legal Counsel with reference to the Committee's continued functions. In view of the national trend toward physician reporting, the AMA is currently examining the possibility of drafting new model legislation with respect to the impaired physician and the relationship of state medical society program to state disciplinary boards.

In summary, the Kansas Board of Healing Arts agrees that KMS committees (Impaired Physicians and Judicial) perform needed and valuable functions. In an unofficial manner, the Board delegates to the Committee the necessary investigative and monitoring functions as may be indicated in each individual case. The Committee would adjudicate a matter in accordance with present laws and KMS By-Laws. Reports to the Board must be made in those cases involving a threat to public welfare. It was the opinion of the Counsel that the committees can function effectively under these guidelines.

In cases of established physician-patient relationship with an impaired member when gross omissions are encountered, it is suggested that the committee member contact the Kansas Medical Society office for a legal opinion. In some cases, a report to the Board may be indicated to fulfill the requirements of the reporting law and thus provide immunity from any retribution suit.

In general, the Committee may proceed with its functions as formerly practiced, including committee discussions of case histories. Under the law, all known impairments must be reported either to the KMS Impaired Physicians Committee or to the Board of Healing Arts. Those cases that are delegated to a particular committee member by the Board of Healing Arts must be reported back to the Board. If the case involves a physician who refuses to cooperate with the committee member, this ends the relationship. The committee member has discharged his/her obligation, but should report that information to the Board.

This Committee has been asked by the Osteopathic Society of Sedgwick County to assist in the establishment of a local program designed for the impaired osteopath, since their statewide program is no longer functional.

Abuse of cocaine and alcohol among medical students and residents, and young people in general, is on the rise nationally. There is extreme reluctance on the part of peers to report such abuse to school authorities. Our Committee will make a concerted effort to develop a better program to deal directly with impaired medical students. Indications are that a program that functions outside the school and is operated by the Medical Society offers the best alternative for the concerned medical student.

Dr. Rhodes participated on the faculty of the 1984 AMA Annual Conference on Impaired Physicians, held in Secaucus, NJ last September, where he was Co-chairman of the special study group. The group recommended that the American Medical Association recognize cocaine addiction to be a disease, similar to alcoholism. Standards need to be established for specialists who treat for this particular disease.

The majority of states now have mandatory reporting laws. Two surveys have conclusively disputed the perception that physicians impaired by alcohol/substance abuse represent a greater malpractice risk.

In general, the KMS program continues to function by establishing a physician/patient relationship between the committee members and those KMS members who are referred to us by individual physicians, hospitals, pharmacists, or others.

Newton C. Smith, M.D., Chairman, submitted the following report for the *Judicial Committee:*

Recently enacted legislation (KSA 65-28,121 and 28,122) made questionable the ability of this committee to continue the performance of its functions. The six specific laws require physicians to report to the Disciplinary Council of the Board of Healing

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Arts any knowledge of prohibited acts performed by a licensee.

Legal opinion obtained from the Board's counsel, and reviewed by KMS Legal Counsel, has established that KMS committees (Judicial and Impaired Physicians) are not precluded from taking whatever action is indicated in individual cases in accordance with KMS By-Laws. Reports to the Board will need to be made only in those cases where a clear violation of licensing law has been established by the Committee.

The Board welcomes KMS committee activity in the area of grievance review, and foresees occasions when the Board may be referring specific cases to our committee for review and adjudication, advising the committee in each case if it may resolve the matter without further board action. While decisions taken by KMS committees are not binding upon the Board, neither is the Board precluded from taking more restrictive action if it deems it necessary. In certain circumstances, members of KMS committees may be asked to investigate or to monitor an individual licensee. The Board will attempt to reimburse the member for expenses in such cases.

KSA 1983 Supp. 65-2898 gives good faith immunity to anyone (including medical associations) who investigates or communicates information to the Board.

The Committee recommends that those cases involving non-member physicians (unless referred to the Committee by the Board) be reviewed on voluntary basis, with concurrence by the physician in question.

This Committee continues to involve county medical societies in dispute resolution, in the belief that most disputes can be best handled at the local level, if addressed quickly and in an impartial manner.

As of April 1, 1985, the Committee has reviewed the following cases:

Patient Complaints Referred to Other Organizations	
Kansas Hospital Association	2
Kansas Association of Osteopathic Medicine	1
Missouri Hospital Association	1
Received for Information Only	
Information Only	3
Case in Litigation	1
Statute of Limitations Expired	1

Withdrawn	
Physician Uncooperativeness	1
Resolved	
Unethical Advertising	1
Medical Ethics	2
Refusal to Treat	1
Fee	2
Pending	
Refusal to Prescribe	1
Refusal to Treat	2
Fee	1
Incompetence	2
Ethics	2

Total Cases Reviewed 24

Erwin T. Janssen, M.D., Chairman of the *Legislative Committee,* advised that an oral in-depth report would be presented during the first session of the House of Delegates.

Robert Haskins, M.D., Chairman, submitted the following report from the *Membership/Insurance Committee:*

The Membership/Insurance Committee has been active in the area of membership recruitment and review of group insurance programs. The membership committee adopted the AMA specialty codes for use in the KMS membership roster; determined that board certification would not be listed in the roster at this time; conducted a special meeting with medical students encouraging membership in KMS; approved the development of a new membership brochure for use in a letter and peer-to-peer membership drive of non-member physicians.

The Insurance Subcommittee, chaired by Ralph Baehr, M.D., Topeka, has been actively working with an insurance broker to review all of the currently endorsed group insurance programs. The Executive Committee authorized Blue Cross-Blue Shield to continue the group health program for another year. The Insurance Committee is now working with the insurance broker to consider the other insurance programs. A special magazine purchase plan will be offered and a Gold Mastercard program is under review.

Jimmie Gleason, M.D., Chairman, submitted the following report from the *Professional Liability Committee:*

The Professional Liability Committee developed and introduced legislation in the State Judiciary Committee. Major provisions of the legislation addressed the standard of care; expert testimony; the collateral source rule; prohibition of punitive damages; limit awards for pain and suffering to $100,000; limit awards to $500,000, excluding future medical costs (total of all damages not to exceed $3,200,000) and limit attorneys fees to 15% of amounts paid from the HCSF.

A compromise version of the legislation passed both the Senate and the House and now awaits the Governor's signature. The compromise contains two major provisions, the collateral source rule and a limitation on punitive damages.

Dr. James Loeffler, chairman of the subcommittee on public relations, has spearheaded a major informational campaign for physicians, legislators, the media, and the public. An informational brochure was developed and distributed widely across the state. Media contacts with TV, radio, and newspapers were developed to tell the story of medical malpractice. Patient information brochures were developed and distributed to physicians' offices.

Max Halley, M.D., F. Calvin Bigler, M.D., Bryce Moore and Bob Fowks are conducting a research project on a no-fault workers compensation approach to the medical malpractice problem. Information from the New Zealand Accident Compensation Corporation and the workers compensation law is being used to develop a model statute. In the near future an actuarial study will be conducted to determine the feasibility of the project.

Roger Warren, M.D., Chairman, submitted the following report of the *Kansas Medical Political Action Committee (KaMPAC):*

The 1984 election year was a very active one for KaMPAC. One-hundred fifty-six state and federal election candidates were supported during the primary and general elections; 145 won their elections for an overall winning percentage of 92%

Members of the KaMPAC Board of Directors and the "200" Club held special meetings with Representatives Slattery, Glickman, Meyers, and Whittaker to discuss issues of medical interest in the Congress. Additional meetings with our other congressional representatives are being planned.

It was my pleasure to again accompany the KMS President, Doctor Bigler, to visit the Council Districts this year.

Following are significant statistics concerning KaMPAC membership and financial activities from 1976-1984:

Membership

1976 — Total 572
1977 — Total 520

KaMPAC

Summary of Income and Expenditures
1976 - 1984 (October 17)

	1976	1977	1978	1979	1980	1981	1982	1983	1984
Cash on Hand Jan. 1	$ 7,388	$ 1,780	$18,896	$ 3,183	$14,836	$ 610	$ 9,270	$ 3,086	$24,929
Receipts	16,940	23,845	11,486	17,413	17,303	14,655	34,386	34,359	41,478
Total Expenditures	22,547	6,729	27,200	5,760	31,530	5,995	40,570	12,515	63,025
AMPAC	8,330	6,660	5,460	4,260	4,330	5,730	11,700	11,710	14,900
Federal	8,000		7,500	1,000	2,750	250	2,950	250	17,250
State	6,217		14,240	500	24,450		25,920	555	30,875
Ending Balance	1,780	18,896	3,183	14,836	610	9,270	3,086	24,929	3,383

KMS Administrative Expenses

1980	$5,400
1981	3,000
1982	3,000
1983	4,000
1984	4,000

AMPAC Contributions to Kansas Candidates

1975-76	$15,300
1977-78	22,350
1979-80	29,875
1981-82	14,087
1983-84	21,000

1978 — Total 349
1979 — Total 302
1980 — Total 210
Regular 181
Sustaining 24
Other 5
1981 — Total 222
Regular 116
Sustaining 89
Other 17
1982 — Total 526
Regular 388
Sustaining 122
Other 16
1983 — Total 514
Regular 380
Sustaining 101 200 Club — 44
Other 33
1984 — Total 642
Regular 401 Regular Education 26
Sustaining 185 Sustaining Education 20 200 Club — 80
Other 10

Resolutions

An asterisk following the resolution number indicates a change in the Constitution and By-Laws.

RESOLUTION NO. 85-1

Educational Information on Hospital Staff Privileges

WHEREAS, The medical staff is empowered by the hospital's governing board to develop a process for the delineation of clinical privileges described in the medical staff by-laws as well as a procedure for medical staff membership; therefore be it

Resolved, That the KMS House of Delegates direct the KMS HMSS to prepare and make available to the medical staffs of the hospitals of Kansas pertinent materials and guidelines to aid the medical staff in the credentialing process; and be it further

Resolved, That the hospital medical staff section work closely with and provide aid to those medical staffs that may lack the expertise or access to qualified personnel to help them; and be it further

Resolved, That the KMS consider and evaluate the possibility of having a seminar on medical staff credentialing and related topics of joint interest to medical staffs and their interactions with their hospital's administration and/or governing boards.

RESOLUTION NO. 85-2

DRGs, PRO, and KFMC

WHEREAS, Resolution 84-21 asked the KMS Council to develop recommendations for areas of increased participation of the Society with the Kansas Foundation for Medical Care with the intent that the philosophy and views of Kansas physicians and patient care remain as the Foundation's top priority; and

WHEREAS, Recommendation #6 of the ad hoc committee was that the KMS Hospital Medical Staff Section hear complaints and continue liaison with KFMC; and

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WHEREAS, The prospective payment system popularly known as DRGs has been inaugurated without adequate testing or demonstration areas; and

WHEREAS, Concerns have been raised that a physician's "DRG cost to the hospital" may be a major factor in determining a staff membership either initial or continuing; therefore be it

Resolved, That the Kansas Medical Society Hospital Medical Staff Section assume the responsibility of receiving, through the KMS administrative staff, and evaluating unresolved complaints by physicians, hospitals, and/or patients regarding the KFMC and develop a mechanism for the effective resolution of complaints with KFMC; and be it further

Resolved, That the Kansas Medical Society Hospital Medical Staff Section be the organization to monitor instances of complications resulting from early discharge under the DRG system, document when indicated the validity of such cases, and forward them to the AMA for their presentation to the proper Federal authority; and be it further

Resolved, That the Kansas Medical Society, through its Hospital Medical Staff Section, request that Medical Staffs of Kansas hospitals, where practical and possible, develop a mechanism to assure that the severity of the patient's illness is considered when any application of DRG statistics is used in evaluation of a physician's practice performance.

RESOLUTION NO. 85-3

Provision of Legal and Administrative Services

WHEREAS, Increased competition and the prospective payment system have driven hospital administrations to seriously re-evaluate their operation; and

WHEREAS, Hospitals are increasingly looking for mechanisms to change operations, and for new sources of revenue, at times without the input or support of their medical staffs; therefore be it

Resolved, That the KMS provide consultation when requested by hospital medical staffs in the areas of legal, administrative, and negotiation services for medical staff issues; and be it further

Resolved, That the KMS determine appropriate staffing, services, and administrative charge requirements to provide such services.



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RESOLUTION NO. 85-4

Practice of Medicine by Unlicensed Individuals

Resolved, That the KMS continue to oppose enactment of new legislation that authorizes independent practice of medicine by individuals who are not licensed to practice medicine and surgery.

RESOLUTION NO. 85-5

DRGs and Medical Staff Privileges

Not adopted; combined with No. 85-2.

RESOLUTION NO. 85-6

Hospital Medical Staff Acting "Under the Influence"

Not adopted; withdrawn.

RESOLUTION NO. 85-7

Hospital Medical Staff Joint Ventures

Resolved, That KMS make available the AMA Hospital Medical Staff Section document that provides a working definition of the term "joint venture," and guidelines for use by hospital medical staff members interested in participating in "joint ventures" to local medical staffs.

RESOLUTION NO. 85-8

Conflict Resolution

Resolved, That the KMS urge hospitals to establish a committee of equal numbers of board of trustees/directors and medical staff representatives to negotiate conflicts and attempt to resolve them as they arise; and be it further

Resolved, That the KMS request the Kansas Hospital Association to join with it to explore mechanisms for the further resolution of unresolved conflicts between hospitals and medical staffs through a mechanism such as a mediation committee composed of equal numbers of physicians and hospital trustees/directors appointed jointly by the component medical society and the hospital association or council.

RESOLUTION NO. 85-9

PRO Regulation

Resolved, That the KMS petition HCFA for those instances in which Medicare Guidelines appear to be medically unsound or contrary to principles of practice and that there be established a prompt means for discussion and resolution of differences between HCFA, the Peer Review Organizations (PROs) and practitioners of medicine.

RESOLUTION NO. 85-10

Quality Assurance for Hospital Sponsored Programs

Resolved, That the KMS urge hospital medical staffs to adopt appropriate quality assurance programs in all hospital sponsored, initiated, or affiliated medical services.

RESOLUTION NO. 85-11

Policy, Management, and Health Economics Education for Graduate Students

Resolved, That the KMS request that the Accreditation Council for Graduate Medical Education evaluate the effectiveness and level of compliance with the requirement in the Essentials of Graduate Medical Education that "instruction in the socioeconomics of health care and in the importance of cost containment should be part of all programs."

RESOLUTION NO. 85-12*

Unified Membership

WHEREAS, American medicine faces ongoing challenges to its ability and responsibility to provide quality care to the American people through socioeconomic pressures, increased state and federal government regulations and cost containment measures, consumerism that places emphasis on cost rather than quality care, professional liability problems again approaching "crisis" proportions in terms of cost, etc.; and

WHEREAS, Specialty societies must and need to speak to the concerns of their members in the "restricted" areas of that specialty; and

WHEREAS, There is a proven need for broader representation than that provided through specialty society membership, important as it is; and

WHEREAS, The AMA can and does speak for all physicians through their elected delegates who set AMA policy and is actively recruiting more members; and

WHEREAS, There will be additional delegate strength for the Kansas Medical Society and finan-

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cial savings to our members through AMA unified state membership; therefore be it

Resolved, That beginning in 1986, the Kansas Medical Society will become a unified state as regards county, state and AMA membership; and be it further

Resolved, That the delegates here assembled take the lead in enlisting their colleagues to join in this effort.

RESOLUTION NO. 85-13

Delegate Allocation

Not adopted.

RESOLUTION NO. 85-14*

By-Laws Changes

1.3 Every qualified physician shall be privileged to apply for membership in an established component society encompassing his/her area of practice.

1.6127 Medical students shall be given full privileges of membership including the right to vote and hold office, and be assessed no annual dues.

2.1 The amount of the annual assessment for the Kansas Medical Society only shall be determined by the Council after consideration of the annual budget for the ensuing year and announced to the various component societies not less than sixty (60) days before the beginning of each fiscal year. Such assessments shall be levied by this Constitution and By-Laws, except that any new member of this Society being accepted by a component society after July 1, shall be assessed one-half the annual sum decided upon by the Council, and shall be accorded all the rights and benefits of this Society, including defense until the succeeding January 1.

3.1 The Society shall hold an annual session at the time and place determined by the Council at the preceding annual session. The date and location of the annual session may be changed by the President subject to the approval of the Council. Provided: that each component society is notified of the change at least five (5) weeks before the new date.

4.51814 Section Otolaryngology-Head and Neck Surgery.

5.412 Second Session:

6.9 The oath of office shall be administered to the President Elect during the President's Banquet and/or Reception at the annual session.

8.12 Associate membership of the Council includes alternate councilors and one (1) representative each from the University of Kansas School of Medicine, the Kansas Department of Health and Environment, the Kansas State Board of Healing Arts, and one (1) representative each from recognized specialty organizations. Associate members may attend plenary sessions of the Council but shall not be entitled to vote.

9.16 Upon reaching a decision, the Judicial Committee chairman shall transmit to the Council and the Board of Healing Arts a written statement and explanation of the final decision as soon as possible after the committee has completed the investigation of the case and has arrived at its decision.

RESOLUTION NO. 85-15

Expiration of 1980 Resolutions

KMS By-Laws — 5.444

"Official policies established through resolutions at the House of Delegates shall be in effect for a period of five (5) years, at which time that policy position will be reviewed by the Executive Committee and will expire subject to the approval by the House of Delegates unless superseded or continued by another resolution."

Changes in the By-laws shall remain in effect until such time as they are amended by the House of Delegates.

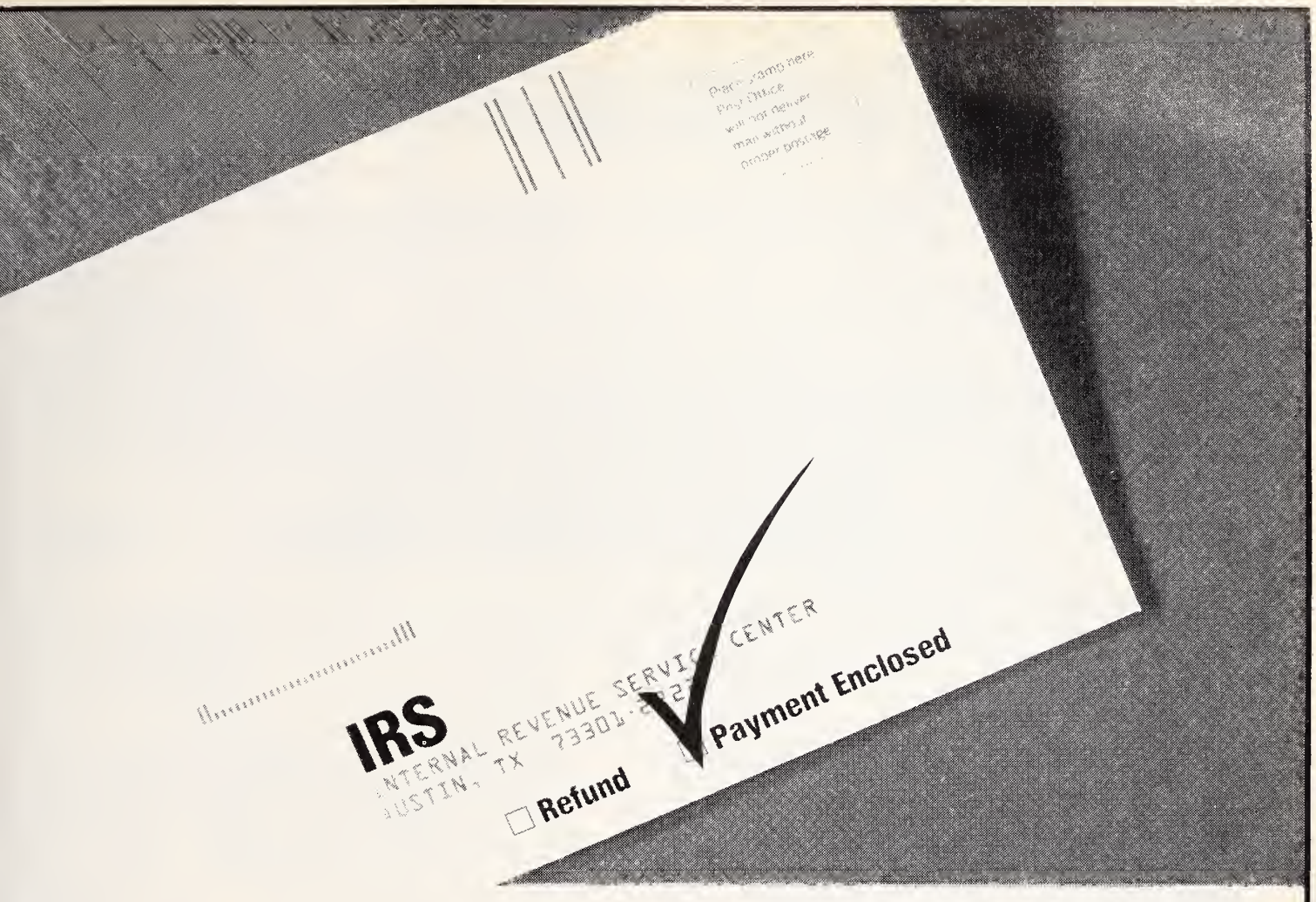
Resolved, That the following 1980 resolutions be re-adopted:

1. Physician's Assistants — Supervision
19. Physician-Hospital Relationships
24. Advanced Registered Nurse Practitioners — Policy Statement

and be it further

Resolved, That the following 1980 resolutions expire:

2. Scientific Basis of Medical Practice
3. Official Policy of the Kansas Medical Society
4. Continuing Medical Education Accreditation
6. Voluntary Effort
9. Principles of Medical Ethics



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10. Facility Position in Adolescent Medicine
11. Periodic Health Assessment
12. Pregnancy Prevention Services for Minors
13. Refunds and One-Half Year Provisions
14. Medicaid Reimbursement Policy
16. Demography of Kansas Physicians — Long Range
18. HCFA Medicare Program
20. Laboratories
21. Physical Therapy
22. Definition: Practice of Medicine
25. Advanced Registered Nurse Practitioners — Teaching Programs
26. MC-Nurse Liaison Committee
27. Ophthalmology Curriculum at the University of Kansas School of Medicine
28. Nuclear Low Level Waste Depositories
29. Journal Advertising
30. Hospital Rate Review
32. 1980 Commendation/1981 Invitation

RESOLUTION NO. 85-16*

Kansas Obstetrical Society

Resolved, That section 4.584 of the KMS By-Laws: Kansas Obstetrical Society; be changed to: Kansas Section, American College of Obstetricians and Gynecology

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RESOLUTION NO. 85-17

Medical School Class Size

WHEREAS, The State Legislature is phasing out its Kansas Medical Scholarship program due to a rapidly declining list of underserved areas in the state and more than 1000 physician-years of contracted service; therefore be it

Resolved, That the KMS study the supply of physicians in the state and its effect on the practice of medicine, and prepare a summary of the findings to be submitted to the executive Committee; and be it further

Resolved, That the KMS investigate the current system of physician placement in the state for resident physicians finishing their residencies to determine a means by which the efficacy of physician placement services can be improved.

RESOLUTION NO. 85-18

Physician Placement Services in Kansas

Not adopted; combined with No. 85-17.

RESOLUTION NO. 85-19

Kansas State Board of Healing Arts Review Committees For Medicine and Surgery, Osteopathy and Chiropractic

WHEREAS, In accordance with enabling legislation which became effective July 1, 1984, review committees representing medicine and surgery, osteopathy, and chiropractic were established to assist the Healing Arts Board's disciplinary counsel in reviewing matters affecting these groups brought to the Board's attention; and

WHEREAS, The individual review committees except in a few instances can make final decisions, thus bypassing the full board; and

WHEREAS, The Board should receive all reports and recommendations of the individual review committees, and retain full decision making authority; therefore be it

Resolved, That the Kansas Medical Society initiate appropriate action to assure all decisions of the individual review committees be subject to review and ratification by the full Board of Healing Arts.

RESOLUTION NO. 85-20

Chiropractic Scope of Practice

Not adopted.

RESOLUTION NO. 85-21

Physician Telephone Listings

Not adopted; referred for study.

WHEREAS, Physician advertising is now permissible under Kansas law if such advertising is not misleading, deceptive, or fraudulent; and

WHEREAS, There are no restrictions or requirements relating to the physician's training as a prerequisite to list under a specific specialty listing in area telephone directories; and

WHEREAS, One ideal of the medical profession is to protect the public's well-being; therefore be it

Resolved, That in cases where it is determined that the physician does not possess specialty training from a recognized training center in the specialty under which he or she lists, that these cases be referred to the Kansas State Board of Healing Arts for review and determination as to whether or not such advertising violates applicable rules and regulations.

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RESOLUTION NO. 85-22

Nursing Care in Nursing Facilities

Not adopted.

RESOLUTION NO. 85-23

DRGs

Not adopted; combined with No. 85-2.

RESOLUTION NO. 85-24

Computers in Medicine

Not adopted.

RESOLUTION NO. 85-25

Commendation

WHEREAS, The House of Delegates voted to provide for Medical Student participation in most of its committees at the 1984 Annual Meeting; and

WHEREAS, The enthusiastic response of the students has been to place a qualified, interested student on those Committees; therefore be it

Resolved, That the Kansas Medical Society accept commendation and thanks from its medical student members for encouraging active participation by the students of the profession in the functioning of the Society.

RESOLUTION NO. 85-26

Tenth Year Celebration of University of Kansas School of Medicine-Wichita (UKSM-W)

WHEREAS, UKSM-W was established by the Legislature on recommendation of the Kansas Board of Regents as a clinical campus of UKSM; and

WHEREAS, Students were first enrolled in the clinical campus in 1974; and

WHEREAS, 405 medical students have graduated from UKSM-W and many of them are now practicing in the state of Kansas; and

WHEREAS, These practicing physicians have made a significant contribution and impact on the health care of Kansans; therefore be it

Resolved, That the UKSM-W Dean, faculty, graduates, and students be congratulated on their accomplishments; and be it further

Resolved, That the Kansas Legislature be highly commended for their wisdom in establishing this clinical campus of UKSM-W; and be it further

Resolved, That a copy of this resolution be sent to Governor John Carlin; members of the Kansas State Board of Regents; Speaker of the House Mike Hayden; President of the Senate Robert V. Talkington; Chancellor Gene Budig, Ed.D.; Executive Vice Chancellor D. Kay Clawson, M.D.; and UKSM Dean William J. Reals, M.D.

RESOLUTION NO. 85-27

Medicare Reimbursement for Anesthesiology Services

WHEREAS, Medicare reimbursement rates for anesthesiologists' services in Kansas are among the lowest in the nation, approximately 45% of usual and customary charges; and

WHEREAS, Medicare reimbursement rates for other medical specialities in Kansas are about the national average, approximately 67 to 75% of usual and customary charges; and

WHEREAS, Anesthesiology charges in Kansas are in the mid to low middle range for anesthesiology charges in other states; and

WHEREAS, Medicare reimbursement rates have been held artificially low for at least 11 years in Kansas; and

WHEREAS, Malpractice rates for anesthesiologists practicing in Kansas are among the highest in the country and higher than rates in California; and

WHEREAS, Blue Cross/Blue Shield as the Medicare Fiduciary for Kansas refuses to pay for anesthesia risk modifiers although this is approved by the Medicare Regional Office and is paid in Missouri; and

WHEREAS, The above considerations make it financially impractical and almost fiscally impossible for an anesthesiologist to routinely accept assignment on Medicare patients; and

WHEREAS, The difficulty in accepting assignment on Medicare patients discriminates against the citizens of Kansas who have paid same into Social Security as citizens of other states but who receive much less on their investment; therefore be it

Resolved, That the Kansas Medical Society recognize the inequities of Medicare reimbursement for anesthesia services provided in the State of Kansas; and be it further

Resolved, That the Kansas Medical Society support the position of the Kansas Society of Anesthesiologists in this matter and provide assistance to correct the inequities.

RESOLUTION NO. 85-28

Annual Jesse Rising Lectureship

WHEREAS, Jesse Rising, M.D., has long been associated with continuing medical education in Kansas; and

WHEREAS, Jesse Rising, M.D., was instrumental in developing the continuing medical education department of the University of Kansas Medical Center and also the Continuing Medical Education Committee of the Kansas Medical Society; and

WHEREAS, Jesse Rising, M.D., recently retired from all continuing medical education activities; and

WHEREAS, The KMS Continuing Medical Education Committee desires to recognize Doctor Rising's long term service to the KMS and to continuing medical education in Kansas; therefore be it

Resolved, That the House of Delegates establish an annual Jesse Rising lectureship as a part of the KMS Annual Meeting.

RESOLUTION NO. 85-29

KMS-PPO

WHEREAS, Multiple provider organizations are forcing physicians to participate in order to assure adequate patient volume; and

WHEREAS, Multiple provider organizations tend to split the physician into many different groups, one against another solely on economic decision; therefore be it

Resolved, That the KMS Executive Committee study the feasibility of developing and implementing a PPO, and report its findings to the Council for action.

RESOLUTION NO. 85-30

Commendation of Ford and Southwest County Societies and Auxiliaries

WHEREAS, The KMS House of Delegates has just completed a most enjoyable and worthwhile annual meeting in the western part of our historical territory; and

WHEREAS, The planning committees have been gracious and hospitable and have provided generously for our comfort and welfare; therefore be it

Resolved, That this House of Delegates extend its appreciation and gratitude to the Ford and Southwest Component Societies and Auxiliaries for their hospitality; and be it further

Resolved, That a copy of this resolution be forwarded to the said component societies and auxiliaries.

Pregnancy with IUD

(Continued from page 231)

the 201, 120 had the IUD left in place and had an abortion rate of 48%. The remaining 81 women whose IUDs were pulled had an abortion rate of 29%. The incidence of subsequent abortion was significantly higher ($P\ 0.02 > 0.01$) in the group in which the IUD was left in place.

More recently, it has been well established that women who become pregnant with an IUD *in situ* are at a particular risk for spontaneous abortion. Shine and Thompson[3] followed 46 pregnancies with IUD *in situ* and found that 49% aborted spontaneously before 20 weeks. An additional four pregnancies (9%) terminated with stillbirths. Vessey[4] reported that in unplanned IUD pregnancies not terminated by elective abortion, 52% ended in miscarriage. This was compared to 17% among women using other methods of birth control — specifically oral contraception or diaphragm — in use at the time of conception. Steven and Fraser[5] reported a 57% rate of fetal loss among 82 women who conceived while using an IUD, more than one-half of which occurred during the second trimester of pregnancy.

Annual Meeting Grants

The Kansas Medical Society is grateful for the grants and contributions received from:

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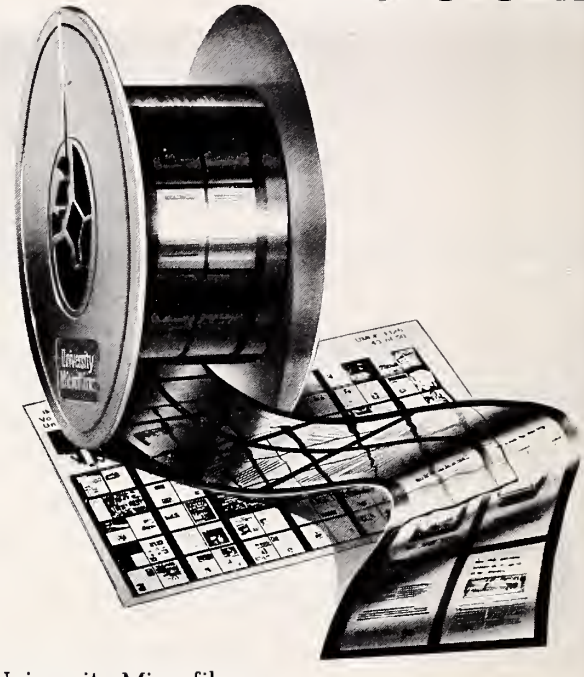
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VOX DOX

Re: Physician Attestation Statement

Vox Dox Editor:

The Health Care Financing Administration recently released new regulations covering the presence of physician attestation statements on each medical record of hospitalized Medicare patients and the penalty statement maintained on file by each hospital. These regulations were issued for implementation by each Peer Review Organization in the U.S.

The Kansas Foundation for Medical Care (KFMC) has developed a new review plan in response to these federal requirements, which states that every Medicare medical record must contain the following statement:

> I certify that the identification of the principal and secondary diagnoses and the procedures are accurate and complete to the best of my knowledge.

This statement must be signed by the attending physician (full original signature) and dated on each medical record before the claim is submitted.

In addition to the above statement, the hospital must maintain a separate file for the following penalty statements signed by all staff physicians:

> Notice to physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

This notice must also be on file when the claim is submitted and must be renewed (signed) annually.

To implement these new regulations, KFMC will identify a representative group of physicians who have active admitting privileges at each hospital and will monitor the file of signed acknowledgments of receipt of the penalty notice at least yearly.

If a current signed acknowledgment is not on file for a physician, KFMC must issue retrospective denials for all claims submitted for which that physician was listed as the attending. All claims for the physician will continue to be denied until a signed acknowledgment of receipt of the penalty notice is on file. This is not a matter of choice for KFMC — we simply must abide by HCFA regulations.

If more than 2.5%, or three — whichever is greater — of the signed acknowledgments are missing or not current, 100% of the hospital's acknowledgment files will be reviewed to determine whether a current signed acknowledgment is on file for all active admitting physicians. KFMC must continue to issue retrospective denials for all claims submitted (whether the signed acknowledgment is *missing* or *not current*) until the notice is on file for that physician.

HCFA has specified that these denial decisions are *not* eligible for reconsideration and are not covered by waiver of liability. Therefore, failure to provide this information, whether it is offensive to one's personal principles or not, can have only a negative impact on the physician's work place, the hospital.

Through its review process, KFMC will share this information with all Kansas hospitals and physicians. If you would like any additional information on this or any other phase of KFMC's review program, please contact KFMC at the Topeka or Wichita offices.

G. Rex Stone, M.D., Medical Director
Kansas Foundation for Medical Care
2953 SW Wanamaker Drive
Topeka KS 66614

IMPAIRED PHYSICIAN PROGRAM DIRECTORY

For information concerning the Impaired Physician Program of KMS or to get help for an impaired colleague, yourself or your spouse, please contact the KMS office or the contact person in your area. All information and identities will be held in strictest confidence, and the caller need not identify himself or herself.

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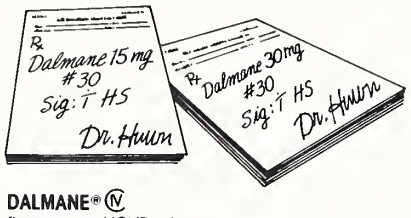
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References: **1.** Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al:* Sympasium on the Treatment of Sleep Disorders, Telecanterence, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



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KANSAS MEDICINE

Volume 86, Number 8, August 1985 ISSN 8755-0059

The Kansas Medical Society

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KANSAS MEDICINE

• The Journal Of The Kansas Medical Society •

Volume 86, Number 8, August 1985

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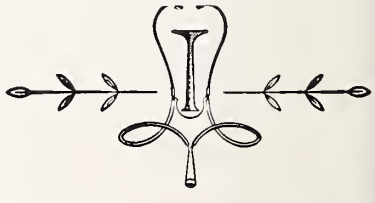
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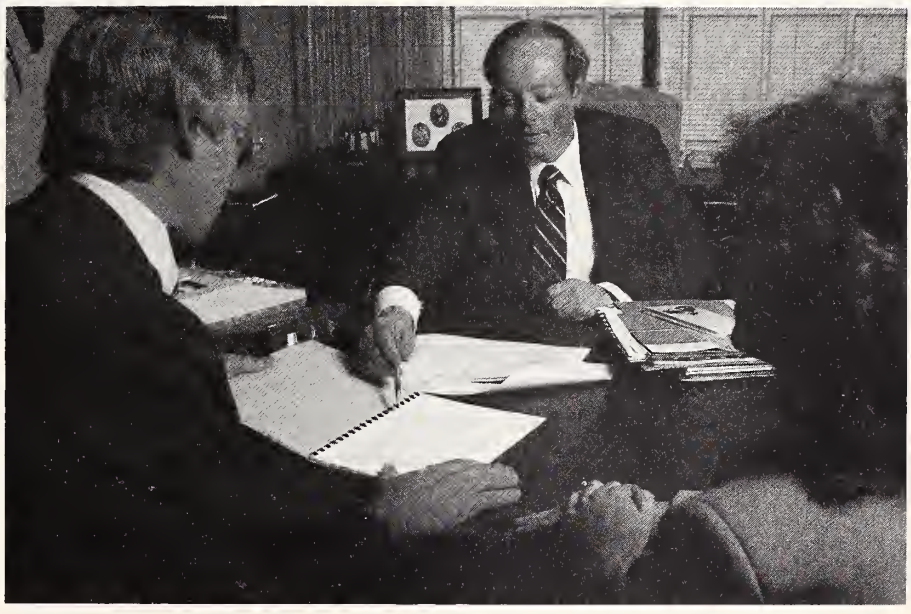


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Principles of MEDICAL ETHICS

Preamble:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Adopted by the A.M.A. House of Delegates
July 20-24, 1980



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Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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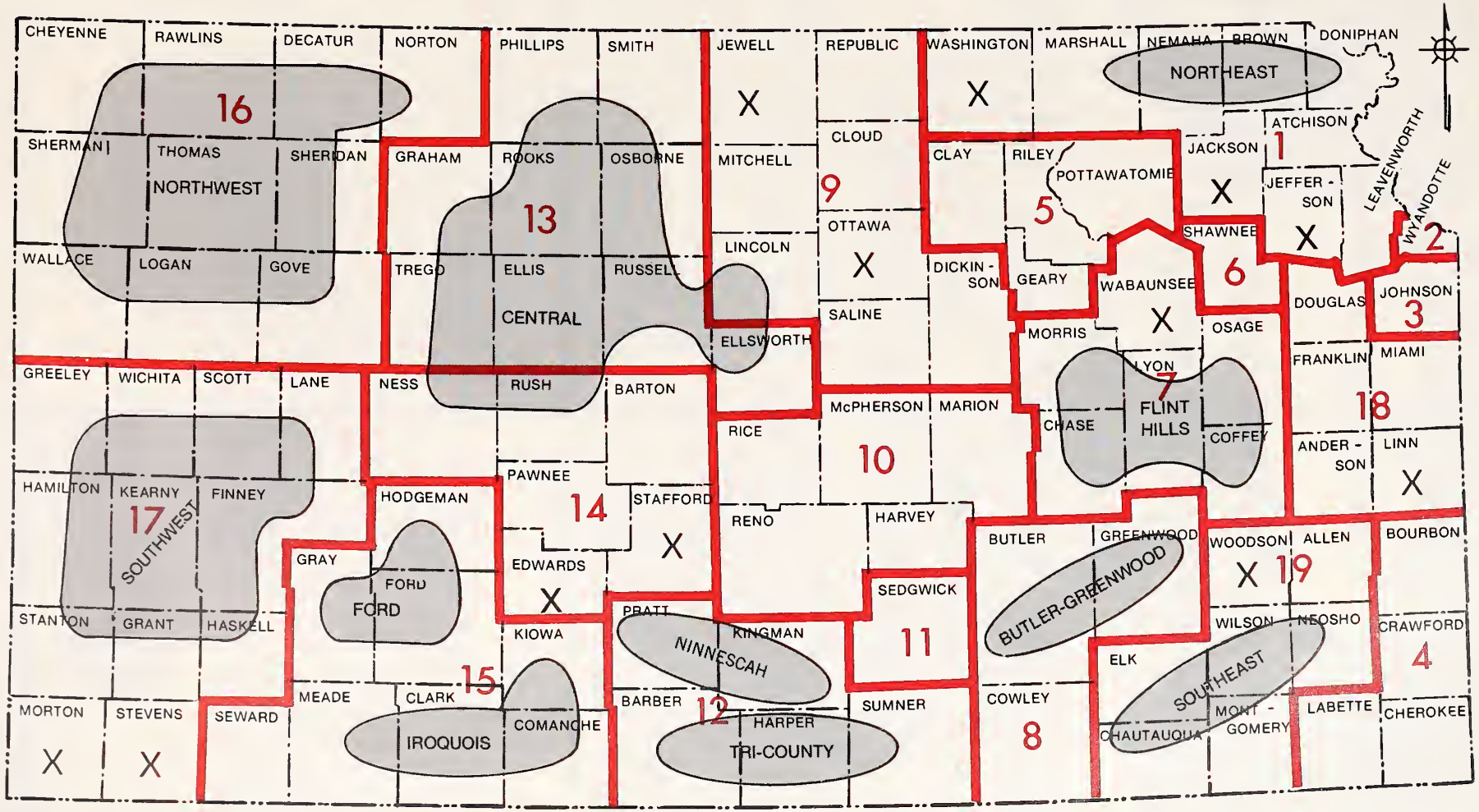
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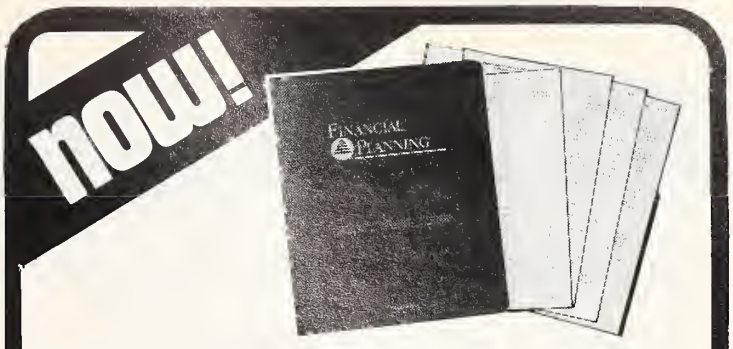
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AMA DELEGATE REPORT

Unified Membership: CME and What It Means to You

Editor's note: The 1985 House of Delegates adopted Resolution #85-12 that mandates unified county-state-national membership effective January 1, 1986. This is the third in a series of short messages to Kansas physicians presented by members of the Kansas AMA delegation.

AMA membership is justified by CME activities alone. Continuing Medical Education is an important element in our professional lives. It is something we are proud to be a part of and willing to accept as an obligation. We can afford to be boastful to our patients and non-medical friends of the many hours we spend in educational endeavors to improve our professional skills.

Various requirements for CME have developed for licensure and organization membership during the past 20 years. Kansas stands alone as the only state requiring specified evidence of CME for both licensure and state medical society membership. Seventeen states have now implemented requirements for licensure.

The AMA has been a strong national influence in the development of quality CME. In 1964 the AMA House of Delegates established accreditation procedures. In 1967 the AMA's Council on Medical Education began to accredit institutions offering courses, and in 1970 the "Essentials of Approved Programs in Continuing Medical Education" emerged. In 1968 the AMA instituted the Physicians Recognition Award (PRA).

After a number of years of involvement, the AMA helped to develop the Accreditation Council for Continuing Medical Education (ACCME) in cooperation with six other organizations: American Board of Medical Specialities, American Hospital Association, Association for Hospital Medical Education, Association of American Medical Colleges, Council of Medical Speciality Societies, and Federation of State Medical Boards.

The ACCME is the organization charged with accrediting CME providers and giving credibility to all organizations offering CME programs for Category 1 credit toward the Physicians Recognition Award of the AMA. You are aware of program announcements showing Category 1 approval, and this statement helps to assure us a quality program.

In an effort to maintain quality, the AMA holds an annual conference for Category 1 CME State and Speciality Society Providers, and in 1984, 47 states were represented.

Your AMA publishes 50 annual issues of the *JAMA* and monthly publications of eight speciality societies. With AMA membership we receive *JAMA* and the speciality journal of our choice. More recently the AMA has made available some 32 CME video clinics for rental or purchase.

For a nominal cost, AMA members can now obtain some 82 different patient information sheets that provide information in lay terms on multiple classes of drugs.

In summary, the AMA plays a vital role in helping us stay abreast of patient care issues by insisting on and monitoring quality. AMA members truly get their money's worth through the AMA effort in CME alone.

Lew W. Purinton, M.D., Wichita
AMA Delegate

Working for Today's Physician

AMA Initiatives for 1985

TEN POINT eight per cent. That's the most recent figure for the health care sector's portion of the U.S. Gross National Product in 1983, up from about 6% of the GNP in 1965. In planning new programs that work for today's physician, the American Medical Association keeps a clear eye on the present realities of medicine — such as the growth that has made health care the nation's third largest industry. The relatively recent increases in aggregate medical expenditures, however, are directly related to many of

the challenges and issues that face the medical profession today:

- Increased government regulations that may freeze fees and put arbitrary caps on reimbursement and restrict access to care;
- Increased competition among doctors, hospitals and alternative health care delivery systems; and
- Increased cost of professional liability insurance.

In developing new initiatives to meet the upcoming changes in the practice of medicine, the AMA is also being guided by its founding mission — to promote the art and science of medicine and the betterment of the public health.

As the medical profession faces continuing health care controversies, it's helpful to review some of the AMA's major areas of emphasis and the broad array of initiatives for 1985.

Preserving the High Quality of Health Care

In 1985, the AMA plans a number of shifts in the direction of scientific and medical education activities to strengthen the interests of the scientific and medical education communities in the organization. This realignment and expansion will include instituting new offices of Basic Research and Education Research, and reorganizing into divisions the AMA efforts regarding undergraduate medical education, graduate medical education, continuing medical education, and education for allied health professions. The AMA also will recruit physician executives to intensify activities in the medical education and scientific areas.

Helping Physicians Respond to a Changing Practice Environment

- The *Market Area Profile (MAP)* is a new and innovative service designed to assist physicians selecting a practice site or in adapting an existing practice to changing market conditions. MAP provides detailed demographic, physician, and hospital data through a unique computer system designed for physicians who recognize the need for market-based information but who are not interested in a high-priced, full-scale market analysis consultation. The data is available for any area in the country.
- The *Physicians' Placement Service* helps those who are looking for new practice situations or locations as well as those who have a position to fill. It offers the most extensive placement listing available for physicians.
- The AMA recently set in motion a "long-range national public education campaign" that will focus on physicians' roles as patient advocates. It is also aimed at increasing the public's understanding of important changes that are occurring in health care delivery and the impact such changes will have on the quality of care and access to it. In addition, the AMA will assist state and county medical societies in similar public information campaigns.

Strengthening Relationships Within the Medical Community:

- New ad hoc committees have been formed to study the concerns of graduates of foreign medical schools and to identify issues of special interest to young physicians.
- In the fall of 1985, the AMA will hold its first National Medical Staff Conference designed to enhance the AMA's leadership role among hospital and health facility medical staffs. A goal of the conference will be to motivate medical staff organizations to become more involved in hospital operations.
- *The Advisory Panel to the Women in Medicine Project* will provide a focal point for activities and information on women physicians in order to strengthen their involvement at all levels of medicine.

Enhancing Health Policy Development

An important policy coordination program for 1985 is *The Health Policy Agenda for the American People*. This is one of the AMA's most significant and successful policy-oriented activities. HPA involves the public and private sectors in the development of comprehensive, long-term guidelines for the establishment of national health policies. The focus in 1985 is to finalize 41 policy proposals that address issues in six areas: medical science; education; health resources; delivery mechanisms; evaluation, assessment and control; and payment for services.

Hundreds of other AMA projects are at work for physicians in the complex, changing medical environment. The emphasis is on preserving the rights of physicians and their patients, and protecting the integrity of American health care. You can help achieve this goal by supporting the AMA.

Your membership is important to us . . . and important to you.

The Kansas Medical Society — 1985-1986

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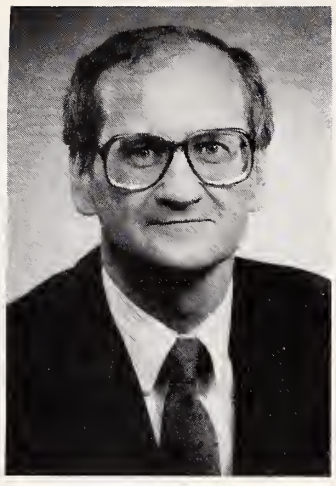
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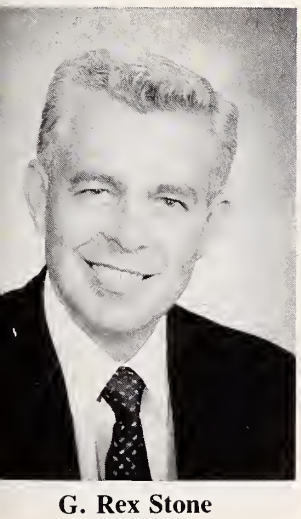
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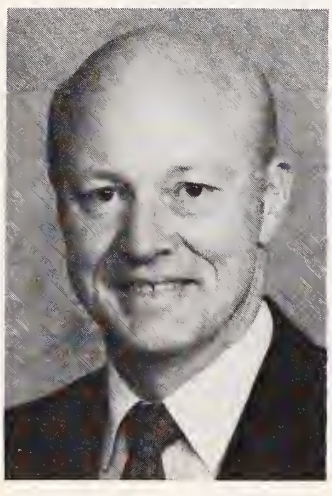
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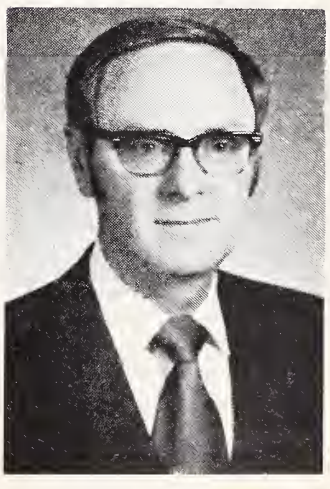
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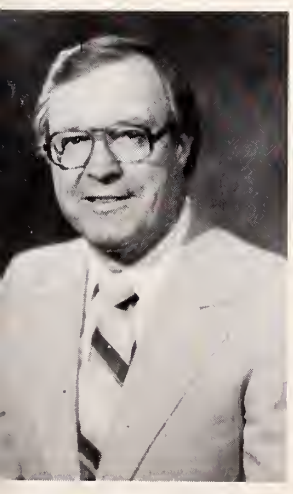
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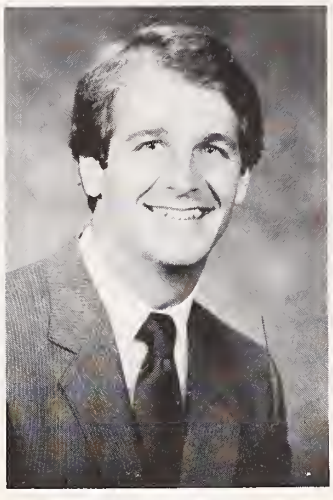


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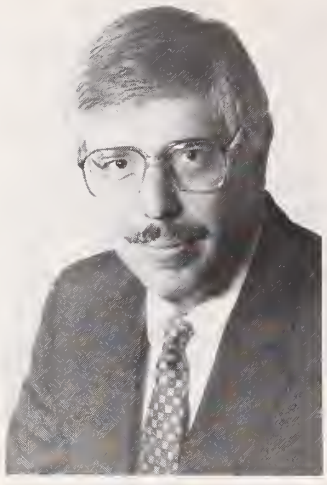


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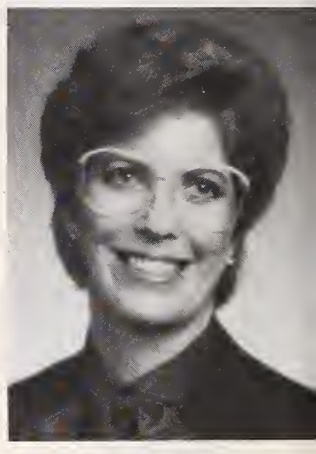
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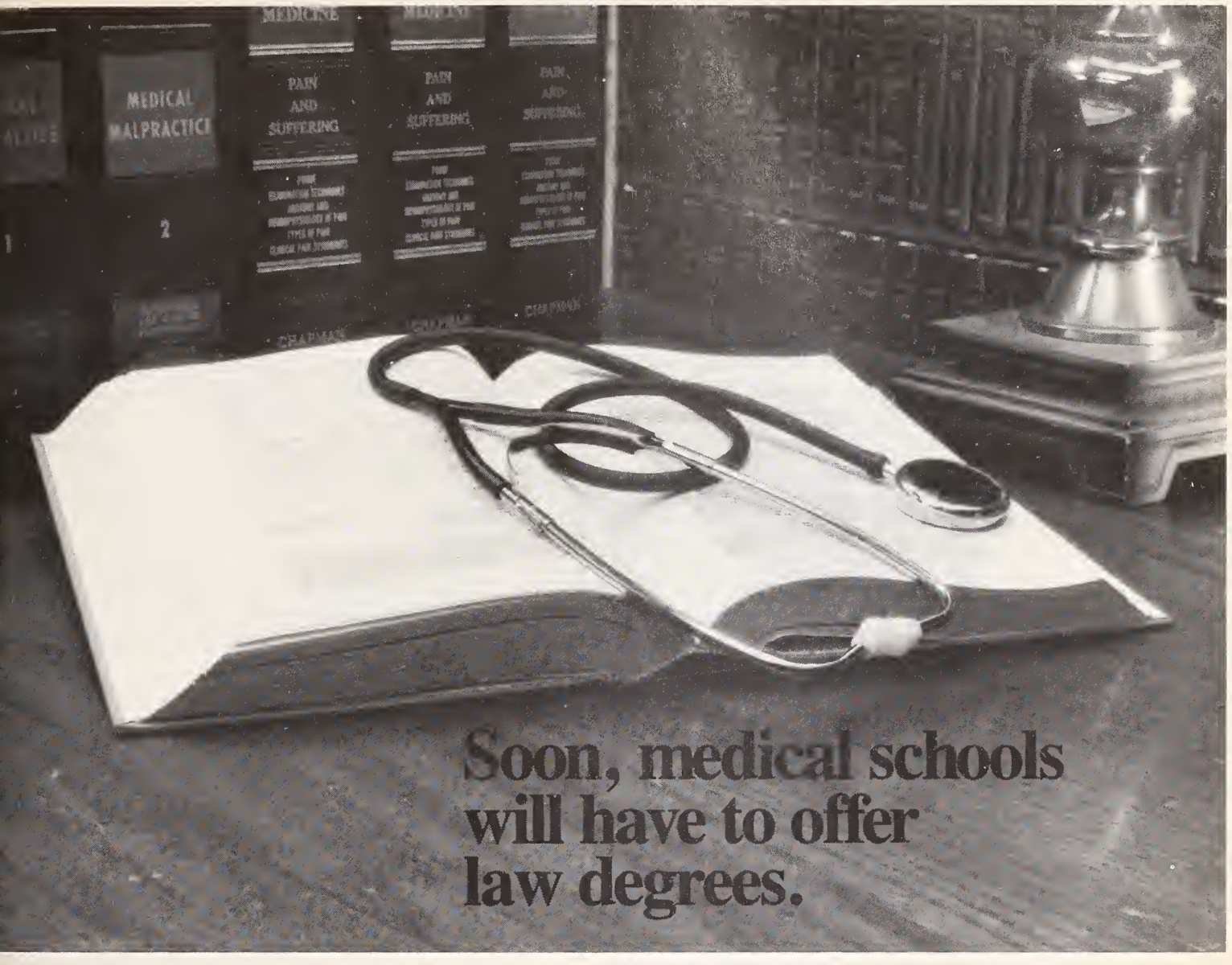
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1. Payroll journal providing monthly totals and division of payroll by type of work performed.
2. Individual earning records indicating the type of work performed. Gross payroll should be totaled by the quarter.
3. Separate record of overtime shown by employee and totaled by class of work for the policy term involved. (Premium for Workers' Compensation is based on straight time pay for all hours worked and does not include ½ extra pay for overtime.) (Not applicable in Delaware, Pennsylvania, and Utah.)
4. Certificates of Workers' Compensation Insurance for all insured sub-contractors.
5. Social Security (Form 941) and State Unemployment Compensation quarterly returns.

Our auditors are instructed to inform you of the date they intend to call on you or to arrange in advance for a convenient time. To assure accurate assignment of your payroll to the proper classes, it is wise for you to arrange to have someone in your organization familiar with employee job assignments available to work with our auditor during the course of the audit.

If your records are kept by an outside accounting firm, make certain the accountants are aware of the impending visit by the auditor so they will have your records available when needed. In the event the accountant is not well informed regarding the duties of various employees, you may wish to brief him/her in advance of the auditor's visit.

In the audit of your payroll for final billing purposes, you need to determine that the payroll of individual employees is assigned to the appropriate rating classification. This assures that you will be paying the correct premium.

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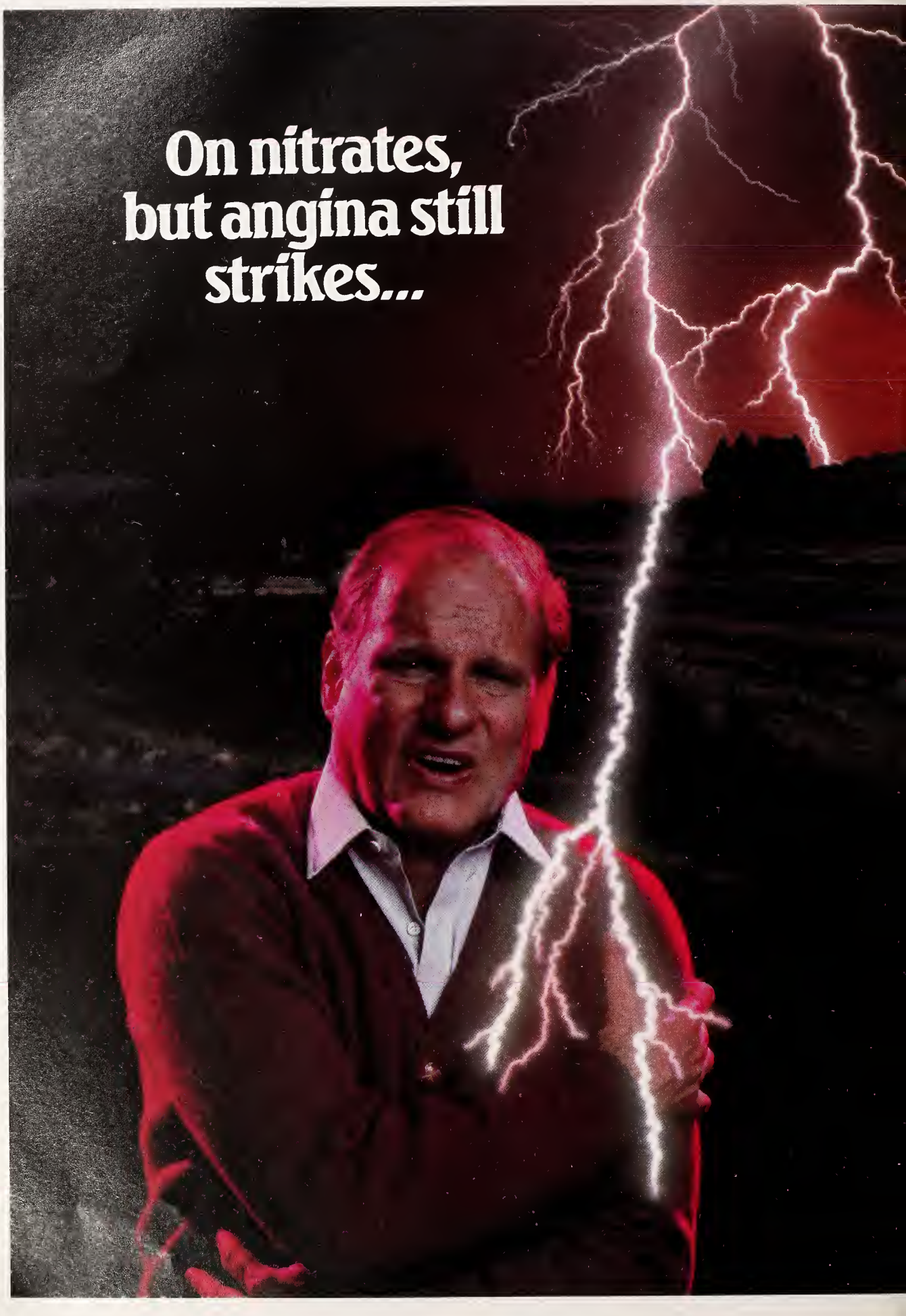
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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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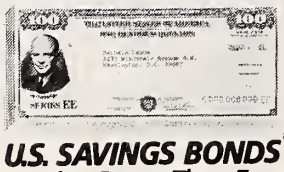


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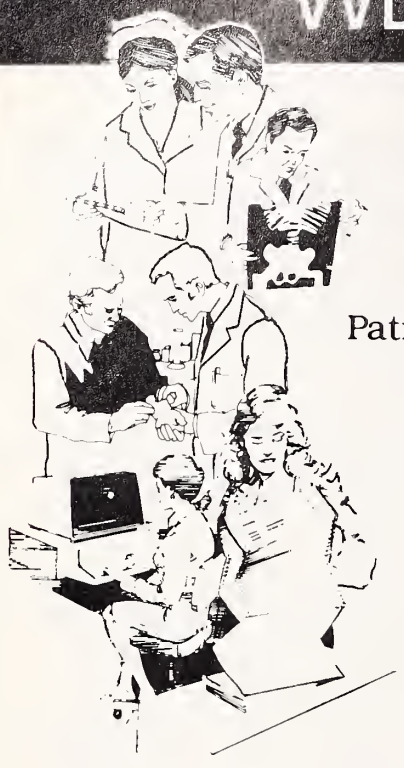
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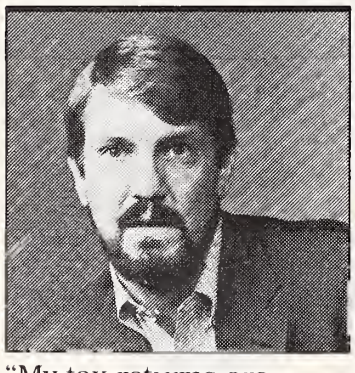
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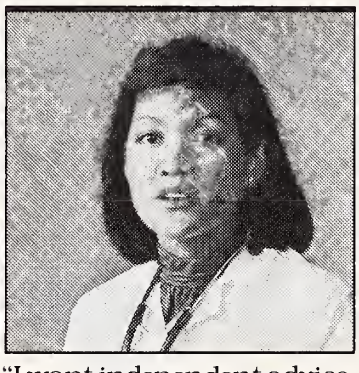
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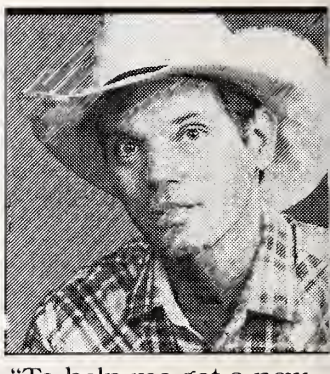
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Salina — Asbury Hospital, P.O. Box 1608 — 913/827-9376, or Kansas City Center

Hays — Post Rock Pediatric Clinic — 913/628-6128, Ext. 29, or Kansas City Center

Parsons — Parsons State Hospital & Training Center — 316/421-6550, Ext. 227, or Kansas City Center

Colby — Citizen's Medical Center — 913/462-7511, Ex. 254, or Kansas City Center

Wichita — Prenatal Diagnosis & Genetic Clinic, Division of Perinatal Medicine, Wesley Medical Center/UKSM-Wichita, 550 No. Hillside, Wichita KS 67214 — 316/688-2360

Wichita — Genetic Clinic, Department of Pediatrics, UKSM-Wichita, 1010 No. Kansas, Wichita KS 67214 — 316/261-2622

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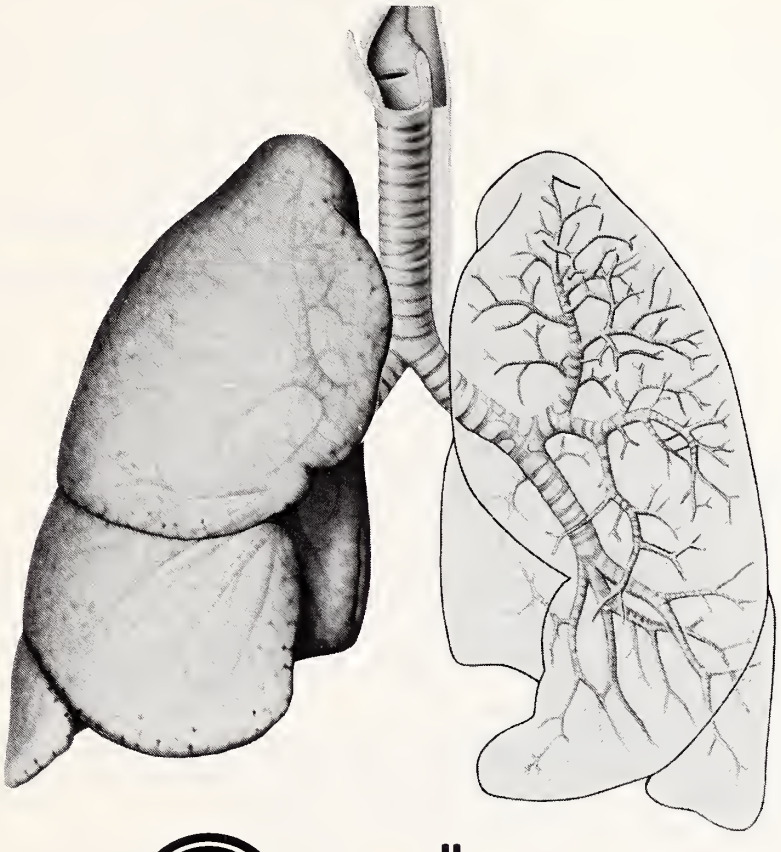
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f Summary. Consult the package literature for prescribing rmation.

cations and Usage: Ceclor* (cetaclor, Lilly) is indicated in the tment of the following infections when caused by susceptible ins of the designated microorganisms:
ower respiratory infections, including pneumonia caused by ptococcus pneumoniae (Diplococcus pneumoniae), Haemoph-influenzae, and S. pyogenes (group A beta-hemolytic ptococci)
ppropriate culture and susceptibility studies should be ormed to determine susceptibility of the causative organism eclor.

traindication: Ceclor is contraindicated in patients with known rgy to the cephalosporin group of antibiotics.

nings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALO-RIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. RE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL SS-ALLERGENICITY OF THE PENICILLINS AND THE HALOSPORINS, AND THERE ARE INSTANCES IN WHICH IENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, BOTH DRUG CLASSES.
ntibiotics, including Ceclor, should be administered cautiously ny patient who has demonstrated some form of allergy, icularly to drugs.
seudomembranous colitis has been reported with virtually all d-spectrum antibiotics (including macrolides, semisynthetic icillins, and cephalosporins); therefore, it is important to sider its diagnosis in patients who develop diarrhea in ociation with the use of antibiotics. Such colitis may range in erity from mild to life-threatening.
reatment with broad-spectrum antibiotics alters the normal a of the colon and may permit overgrowth of clostridia. Studies cate that a toxin produced by *Clostridium difficile* is one ary cause of antibiotic-associated colitis.
ild cases of pseudomembranous colitis usually respond to discontinuance alone. In moderate to severe cases, manage-ment should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.
Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.
Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.
Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.
As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).
Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.
Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.
Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.
Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).
Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.
Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).
Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.
Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).
Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).
Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cetaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.
Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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3305 College of Medicine & Dentistry of New Jersey — New Jersey Medical School, Newark

3401 University of New Mexico School of Medicine, Albuquerque

3501 Columbia University College of Physicians and Surgeons, New York
3503 Albany Medical College of Union University, Albany
3506 State University of New York at Buffalo, School of Medicine, Buffalo
3508 State University of New York College of Medicine, Brooklyn
3509 New York Medical College, New York
3510 Bellevue Hospital Medical College, New York
3515 State University of New York College of Medicine, Syracuse
3519 New York University School of Medicine, New York
3520 Cornell University Medical College, New York
3545 University of Rochester School of Medicine and Dentistry, Rochester
3546 Albert Einstein College of Medicine of Yeshiva University, New York

3601 University of North Carolina School of Medicine, Chapel Hill
3605 Bowman Gray School of Medicine, Winston-Salem
3607 Duke University School of Medicine, Durham

3802 Eclectic Medical College, Cincinnati
3806 Case Western Reserve University School of Medicine, Cleveland
3840 Ohio State University College of Medicine, Columbus
3841 University of Cincinnati College of Medicine, Cincinnati
3843 Medical College of Ohio at Toledo, Toledo

3901 University of Oklahoma School of Medicine, Oklahoma City
3979 Oklahoma College of Osteopathic Medicine and Surgery, Tulsa

4002 University of Oregon Medical School, Portland

4101 University of Pennsylvania School of Medicine, Philadelphia
4102 Jefferson Medical College of Thomas Jefferson University, Philadelphia
4107 Medical College of Pennsylvania, Philadelphia
4109 Hahnemann Medical College and Hospital, Philadelphia
4112 University of Pittsburgh School of Medicine, Pittsburgh
4113 Temple University School of Medicine, Philadelphia
4114 Pennsylvania State University, Milton S. Hershey Medical Center, Hershey
4177 Philadelphia College of Osteopathic Medicine, Philadelphia

4201 University of Puerto Rico School of Medicine, San Juan

4301 Brown University Division of Biological and Medical Sciences, Providence

4501 Medical University of South Carolina College of Medicine, Charleston

4705 Vanderbilt University School of Medicine, Nashville
4706 University of Tennessee College of Medicine, Memphis
4707 Meharry Medical College School of Medicine, Nashville

4802 University of Texas Medical Branch, Galveston
4804 Baylor College of Medicine, Houston
4812 University of Texas Southwestern Medical School, Dallas
4813 University of Texas Medical School, San Antonio

4814 University of Texas Medical School, Houston

4901 University of Utah College of Medicine, Salt Lake City

5002 University of Vermont College of Medicine, Burlington

5101 University of Virginia School of Medicine, Charlottesville
5104 Medical College of Virginia Health Sciences Division of Virginia Commonwealth University, Richmond
5107 Eastern Virginia Medical School, Norfolk

5404 University of Washington School of Medicine, Seattle

5501 West Virginia University School of Medicine, Morgantown

5605 University of Wisconsin Medical School, Madison
5606 Medical College of Wisconsin, Milwaukee

FOREIGN MEDICAL SCHOOL CODES

CANADA

060 Alberta
06001 University of Alberta Faculty of Medicine, Edmonton
06002 University of Calgary Faculty of Medicine, Calgary

061 British Columbia
06101 University of British Columbia Faculty of Medicine, Vancouver

062 Manitoba
06201 University of Manitoba Faculty of Medicine, Winnipeg

065 Ontario
06501 University of Toronto Faculty of Medicine, Toronto
06505 Queen's University Faculty of Medicine, Kingston

067 Quebec
06701 McGill University Faculty of Medicine, Montreal

OTHER FOREIGN

118 Afghanistan
11801 Faculty of Medicine, Kabul University, Kabul

132 Argentina
13201 Facultad de Ciencias Medicas de la Universidad de Buenos Aires, Buenos Aires
13202 Facultad de Ciencias Medicas de la Universidad Nacional de Cordoba, Cordoba
13204 Facultad de Ciencias Medicas, Farmacia y Ramos Menores de la Universidad Nacional del Litoral, Rosario, Santa Fe
13206 Facultad de Ciencias Medicas de la Universidad Nacional de Cuyo, Mendoza, Mendoza

143 Australia
14303 Faculty of Medicine University of Sydney, Sydney, New South Wales

154 Austria
15407 Medizinische Fakultat der Universitat Wien, Wien (407-26 from March 13, 1938 to June, 1945)

165 Belgium
16501 Faculte de Medecine et de Pharmacie Universite libra de Bruxelles, Bruxelles

176 Bolivia
17602 Facultad de Ciencias Medicas de la Universidad Mayor Real y Pontificia de San Francisco Xavier de Chuquisaca, Sucre
17603 Facultad de Medicina de la Universidad Mayor de San Simon, Cochabamba

187 Brazil
18708 Universidade Federal de Parana, Faculdade de Medicina, Curitiba, Parana

215 Cambodia
21501 Ecole Royal de Medicine Du Cambode, Phnompenh

231 Chile
23101 Facultad de Medicina de la Universidad de Chile, Santiago

242 China
242 China (also see 243 Effective January 1, 1977)
24209 St. John's University (Pennsylvania Medical School, Shanghai, Kiangsu (Extinct)
24216 National Shanghai Medical College, Shanghai, Kiangsu
24217 West China Union University College of Medicine and Dentistry, Chengtu, Szechuan
24222 Aurora University Faculty of Medicine, Shanghai, Kiangsu (Extinct)
24239 Shansi University Medical College, Taiyuan, Shansi

243 China
24338 National Honan University Medical College, Kaifeng, Honan (24238 Prior to 1-17-1)
24351 National Defense Medical Center, School of Medicine, Shanghai, Kiangsu (24251 Prior to 1-17-1)

244 Taiwan
244 Taiwan (Formosa) effective 1-17-1
24402 College of Medicine National Taiwan University, Taipai (38502 Prior to 1-17-1)
24404 Taipai Medical College, Taipai (38504 Prior to 11-71)

264 Colombia
26401 Facultad de Medicina de la Universidad Nacional de Colombia Cuidad Universitaria, Bogota, Cundinamarca
26402 Faculdad de Medicina de la Universidad de Cartagena, Cartagena, Bolivar
26404 Facultad de Medicina de la Pontificia Universidad Javeriana, Bogota, Cundinamarca
26406 Facultad de Medicina de la Universidad de Caldas, Manizales, Caldas
26407 Facultad de Medicina de la Universidad del Cauca, Popayan, Cauca

275 Cuba
27501 Facultad de Medicina de la Universidad de la Habana, La Habana

286 Czechoslovakia
28602 Charles Univerzita Fakulta of PedGen Medicine, Praha

308 Dominican Republic
30801 Facultad de Medicina de la Universidad de Santo Domingo, Ciudad, Trujillo

319 Ecuador
31901 Facultad de Ciencias Medicas de la Universidad Central, Quito

330 Egypt (United Arab Republic)
33002 Kasr-el-AiniFaculty of Medicine Cairo University, Cairo (Formerly Fouad First University Faculty of Medicine)
33003 Faculty of Medicine Alexandria University, Alexandria
33004 Abbasis Faculty of Medicine, University of Ein Shams, Cairo

341 El Salvador
34104 Facultad de Medicina Universidad Nacional del Salvador, San Salvador

352 England
35205 School of Medicine University of Leeds, Leeds
35207 University of London Faculty of Medicine, London
35211 Registrable Qualifications granted by English Conjoint Board (Royal College of Surgeons of England/Royal College of Physicians of London)

385 Formosa (Taiwan)
385 (Also see 244 Taiwan [Effective 1-17-1])
38501 Kaohsiung (takau) Medical College, Kaohsiung
38502 College of Medicine National Taiwan University, Taipai
38503 National Defense Medical Center, Taipai
38505 China Medical College, Taichung

396 France

39606 Faculte de Medecine de l'Universite de Paris, Paris, Seine

39607 Faculte mixte de Medecine et de Pharmacie de l'Universite de Toulouse, Toulouse, Haute-Garonne

407 Germany

407 Also see 408409—East and West Germany (Effective 1-1-71)

40707 Medizinische Fakultat der Georg-August-Universitat, Gottingen, Niedersachsen

40710 Medizinische Fakultat der Universitat Heidelberg, Heidelberg, Baden-Wurttemberg

40715 Medizinische Fakultat der Phillipps-Universitat, Marburg/Lahn, Hessen

40716 Medizinische Fakultat der Ludwig Maximiliams-Universitat, Munchen, Bayern

40721 Medizinische Fakultat der Universitat Hamburg, Hamburg

40723 Medizinische Fakultat der Johann-Wolfgang-Goethe-Universitat, Frankfurt-Am-Main, Hessen

40733 Medizinische Fakultat der Freien Universitat Berlin, Berlin

409 Germany West

40905 Medizinische Fakultat Albert-Ludwigs-Universitat Freiberg IM Breisgau

40933 Medizinische Fakultat Freien Universitat, Berlin, Berlin (40733 Prior to 1-1-71)

418 Greece

41801 Faculty of Medicine National University of Athens, Athens

41802 Faculty of Medicine University of Thessaloniki, Thessaloniki

429 Guatemala

42901 Facultad de Ciencias Medicas, Universidad de San Carlos, Guatemala

451 Honduras

45101 Facultad de Medicine y Cirugia de la Universidad Nacional Autonoma de Honduras, Tegucigalpa

473 Hungary

47301 Orvosi Fakultas Tudomanyegyetem, Budapest

495 India (Goa)

49501 University of Bombay, Affiliated Medical Colleges are:

a. Grant Medical College Bombay University, Bombay, Maharashtra

b. Seth Gorhandas Sunderdas Medical College Bombay University, Bombay, Maharashtra

49504 Madras Medical College Madras University, Madras, Madras

49508 Christian Medical College Punjab University, Ludhiana, Punjab

49509 St. John's Medical College, Bangalore, Mysore (before June 1966: Government Medical College, Mysore University, Mysore)

49511 Andhra Medical College Andhra University, Visakhapatnam, Andhra

49516 Stanley Medical College Madras University, Madras, Madras

49518 Assam Medical College Gauhati University, Dibrugarh, Assam

49521 Osmania Medical College Osmania University, Hyderabad, Andhra

49523 Medical College Baroda University, Baroda, Gujarat

49527 Christian Medical College, Vellore, Madras

49528 Byramjee Jeejeebhoy Medical College, Poona, Maharashtra

49529 Government Medical College Punjab University, Patiala, Punjab

49530 Sawai Man Singh Medical College Rajasthan University, Jaipur, Rajasthan

49531 Medical College Kerala University, Trivandrum, Kerala

49534 Gajra Rajo Medical College Vikram University, Gwalior, Madhya Pradesh

49535 Karnatak Medical College Karnatak University, Hubli, Mysore

49536 All-India Institute of Medical Sciences, New Delhi, Delhi

49537 Kasturba Medical College Karnatak University, Manipal, Mysore

49541 G.S.V. Memorial Medical College Lucknow University, Kampur, Uttar Pradesh

49547 Medical College Jabalpur University, Jabalpur, Madhya Pradesh

49548 M.P. Shah Medical College Gujarat University, Jamnagar, Gujarat

49549 Ghandhi Medical College Vikram University, Bhopai, Madhya Pradesh

49550 Guntur Medical College Andhra University, Guntur, Andhra

49554 Rajendra Medical College, Ranchi, Bihar

49555 Sardar Patel Medical College, Bikaner, India
49557 Kakatiya Medical College, Warangal, Andhra Pradesh
49568 College Medicine Sciences Banaras Hindu University, Varanasi, Uttar Pradesh
49576 Municipal Medical College, Gujarat University, Ahmedabad, Gujarat
49596 Lokmanya Tilak Mun Medical College, Bombay University, Bombay, Maharashtra
49597 Dr. Vaishampayan Memorial Medical College, Shivaji University, Shalopur, Maharashitra

496 India
49611 Sri Krishna Medical College, Muzaffarpur, Bihar

506 Indonesia
50602 Faculty of Medicine Airlangga Airlangga University, Surabaya

517 Iran
51701 Faculty of Medicine University of Teheran, Teheran

528 Iraq
52801 Faculty of Medicine Baghdad University, Baghdad

539 Ireland
53901 Faculty of Medicine Queen's University of Belfast, Belfast
53902 National University of Ireland, Constitient Colleges are:
a. Faculty of Medicine University College, Dublin
b. Faculty of Medicine University College, Cork
c. Faculty of Medicine, Galway
53903 School of Physic Trinity College University of Dublin, Dublin

550 Israel
55001 The Hebrew University-Hadassah Medical School, Jerusalem

561 Italy
56115 Facolta di Medicina e Chirurgia dell'Universita di Perugia, Perugia
56119 Facolta di Medicina e Chirurgia dell'Universita di Siena, Siena

572 Japan
57211 Tokyo Medical College (Nippon Ikadaigaku) Hongo, Tokyo (Extinct)
57241 Faculty of Medicine Shinshu University, Matsumoto, Nagano
57249 Tokyo Medical College, Tokyo

583 Korea (South)
58301 Severence Medical College Yonsei University, Seoul
58302 College of Medicine Seoul National University, Seoul
58303 Korea University Medical College, Seoul
58304 College of Medicine Kyong-Puk National University, Taegu
58306 College of Medicine Chun Nam National University, Kwangiu
58309 College of Medicine Pusan National University, Pusan
58310 College of Medicine Catholic University, Seoul

605 Lebanon
60501 Medical School American University of Beirut, Beirut

627 Malta
62701 Faculty of Medicine and Surgery Royal University of Malta, Valetta

649 Mexico
64901 Facultad de Medicina de la Universidad Nacional Autonoma de Mexico, Mexico
64902 Facultad de Medicina de la Universidad de Nuevo Leon, Monterrey, Nuevo Leon
64906 Facultad de Medicina de la Universidad Nacional del Sureste, Merida, Yucatan
64914 Facultad de Medicina de la Universidad Autonoma de Guadalajara, Guadalajara, Jalisco
64936 Centro de Estudios Universidad Xochicalo A.C., Cuernavaca, Morelos

660 Netherlands
66061 Faculteit der Geneeskunde Universiteit Van Amsterdam, Amsterdam

671 New Zealand
67101 Medical School University of Otago, Dunedin

704 Pakistan
70401 King Edward Medical College, Lahore, West Pakistan
70402 Dow Medical College, Karechi, Federal Capital Area
70403 Dacca Medical College, Dacca, East Pakistan
70404 Nishtar Medical College, Multan, West Pakistan
70409 Khyber Medical College, Peshawar, North-West Frontier Province
70410 Chittagong Medical College, Chittagong, East Pakistan (16001 after 7-1-72)

726 Paraguay
72601 Facultad de Medicina de la Universidad Nacional de Asuncion, Asuncion

737 Peru
73701 Facultad de Medicina de San Fernando de la Universidad Nacional Mayor de San Marcos, Lima
73705 Facultad de Medicina de la Universidad Nacional de San Agustin, Arequipa
73706 Facultad de Medicina "Cayetano Heredia" de la Universidad Peruana de Ciencias Medicas y Biologicas, Lima

748 Phillipines
74801 Faculty of Medicine and Surgery University of Santo Tomas, Manila
74802 College of Medicine University of the Phillipines, Manila
74807 College of Medicine Manila Central University, Manila
74808 Institute of Medicine Far Eastern University, Manila
74809 College of Medicine Southwestern University, Cebu City
74810 College of Medicine University of the East, Quezon City
74811 College of Medicine Cebu Institute of Technology, Cebu City

803 Scotland
80301 Faculty of Medicine University of Aberdeen, Aberdeen
80302 University of St. Andrews School of Medicine, Dundee
80303 Faculty of Medicine University of Edinburgh, Edinburgh

836 South Africa
83601 Medical School University of the Witwatersrand, Johannesburg

847 Spain
84701 Facultad de Medicina de la Universidad de Barcelona, Barcelona
84703 Facultad de Medicina de la Universidad de Grenada, Grenada
84704 Facultad de Medicina de la Universidad de Madrid, Madrid
84706 Faculdad de Medicina de la Universidad de Zaragoza, Zaragoza
84708 Facultad de Medicina de la Universidad de Valencia, Valencia
84710 Facultad de Medicina de la Universidad de Salamanca, Salamanca
84711 Facultad de Medicine de la Universidad Catolica Navarra, Pamplona

869 Switzerland
86901 Medizinische Fakultat der Universitat Basel, Basel
86902 Medizinische Fakultat der Universitat Bern, Bern
86905 Faculte de Medecine de l'Universite de Lausanne, Lausanne

875 Syria
87501 Faculty of Medicine Damascus University, Damascus

Taiwan (See Formosa)

891 Thailand
89101 Faculty of Medicine at Chulalongkorn Hospital University of Medical Sciences, Bangkok
89102 Faculty of Medicine at Sariraj Hospital University of Medical Sciences, Thonburi
89104 Faculty of Medicine at Ramathibodi Hospital, Mahidol University, Bangkok

902 Turkey
90201 Tip Fakultesi Istanbul Universitesi, Istanbul
90205 Haceteppe University Faculty of Medicine, Ankara

913 Union of Soviet Socialist Republics
91302 Voronez Medical Institute, Voronez

941 Viet-Nam South
94101 Faculte mixte de Medicine et de Pharmacie Universite de Saigon, Saigon

957 Yugoslavia
95702 Medicinski Fakultet Univerziteta u Beogradu, Beograd

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BEAL, RAYMONO J, FREOONIA
BEALE, DAVID A, TOPEKA
*BEAMER, LARRY R, WICHITA
BEARCE, SHARON K, WICHITA
BEATY, JAMES R, MAYETTA
BEBAK, OONALO M, WICHITA
BECK, CHARLES W, WICHITA
BECK, JOSEPH O, TOPEKA
BECK JR, CALVIN E, KANSAS CITY,MO
BECKER, BRYAN N, SHAWNEE MISSION
BECKER, KARL E, WICHITA
BECKER, LESLIE E, KANSAS CITY
BEOFORO, O R, TOPEKA
BEEBE, EOMER, OLATHE
BEELMAN, FLOYO C, TOPEKA
BEEZLEY, MICHAEL J, SHAWNEE MISSION
BEGGS, OAVIO F, GARDEN CITY
BEHRHORST, CARROLL O, GUATEMALA,
BEILMAN, GREG J, KANSAS CITY
BEJAR, JOSE M, KANSAS CITY
BELCHER, GEORGE O, COLUMBUS
BELOEN, MARY J, SHAWNEE MISSION
BELL, OELORIS W, SHAWNEE MISSION
BELL, GREGORY A, KANSAS CITY
BELL, MARK G, SALINA
BELLER, WILLIS L, TOPEKA
BELOT JR, MONTI L, LAWRENCE
BELT, ROBERT J, SHAWNEE MISSION
BELZ, MICHAEL K, SHAWNEE MISSION
BELZER, EOWARO G, SHAWNEE MISSION
BENA, JAMES H, PITTSBURG
BENAGE, JOHN F, FORT SCOTT
BENNETT, CHARLES A, KANSAS CITY,MO
BENNETT, S H, KANSAS CITY,MO
BENSON, DAVID R, SHAWNEE MISSION
BENSON, KIRK T, KANSAS CITY
BENTON, JAY S, NEWTON
BERGER, WILLIAM, SHAWNEE MISSION
BERGIN, JAMES J, KANSAS CITY
BERKEY, VERNON A, PITTSBURG
BERKLEY, OON H, ABILENE
BERKLEY, NORMAN W, SENECA
BERNER, NEAL E, COLLYER
BERRIOGE, OEBRA L, KANSAS CITY
BERRY, JOHN M, SHAWNEE MISSION
BETHEL, CHANOLER S, WICHITA
BETTIN, BRYCE O, KANSAS CITY
BETTY, JANE M, KANSAS CITY
BEUGELSOIJK, HENRY PETER, HALSTEAO
BHARGAVA, ASHOK KUMAR, LA CROSSE
BHARGAVA, BAIKUNTH N, WICHITA
BHARGAVA, SHOBHANA, LA CROSSE
BIBERSTEIN, GREG A, WICHITA
BICHLMEIER, FRANKLIN G, KANSAS CITY
BIERI, PETER V, LAWRENCE
BIERLEIN, KENNETH J, PITTSBURG
BIERMANN, HENRY J, WICHITA
BIERMANN, WILLIAM J, WICHITA
BIGGS, OENNIS, ABILENE
BIGLER, F CALVIN, GARDEN CITY
BIGONGIARI, LAWRENCE R, WICHITA
BIKALES, VICTOR WILLIAM, SHAWNEE MISSION
BILLINGS, THOMAS, MCPHERSON
BILLINGSLEY, THAO H, SHAWNEE MISSION
BINGAMAN, ROBERT W, WICHITA
BINYON, KERNIE W, WICHITA
BISHOP, FRANCIS E, SHAWNEE MISSION
BISHOP, HENRY R, SHAWNEE MISSION
BISHOP, ROONEY LEE, LAWRENCE
BITTENBENOER, LEE R, LAWRENCE
BIKLER II, THOMAS J, KANSAS CITY
BLACK, CYRIL V, PRATT
BLACK, OAVIO L, KANSAS CITY
BLACK, WILLIAM L, COLORAOO SPGS,CO
BLACKBURN, ROBERT W, COUNCIL GROVE
BLACKBURN, TIMOTHY L, KANSAS CITY
BLAKE, HENRY S, TOPEKA
BLAKELEY, SHARON L, OTTAWA
BLAKELY, KENT W, KANSAS CITY
BLANK, JOHN N, HUTCHINSON
BLANKENSHIP, JIM O, OTTAWA
BLAYLOCK, HOYT C, WICHITA
BLETZ, OONALO B, SHAWNEE MISSION
BLIM, R OON, KANSAS CITY,MO
BLISS, JOY V, OLATHE
BLOMQUIST, GLENDA L H, KANSAS CITY
BLOOM, L THEIL, KINGMAN
BLOOM, ROONEY LAMONT, WICHITA
BLOKHAM, THOMAS J, WICHITA
BLUM, MICHAEL A, O.O., OLATHE
BOCK, PETER A, WICHITA
BODENSTEINER, OAVIO C, KANSAS CITY
BOEHM, OOUGLAS K, WICHITA
BOEHM, MINOY M, WICHITA
BOESE, KENNETH M, MANHATTAN
BOGNER, PAUL F, CLAY CENTER
BOLES, J MICHAEL, SHAWNEE MISSION
BOLES, R OALE, OOOGE CITY
BOLING, JAMES M, KANSAS CITY
BOLINGER, ROBERT E, KANSAS CITY
BOLLIER, RENE P, HOUSTON,TX
BOLLMAN, CHARLES S, JUNCTION CITY
BOLT, MICHAEL, NEWTON
BONO, ROGER C, WICHITA
BONEBRAKE, C RICHARO, TOPEKA
BOREL, OAVIO, TOPEKA
BORGENOALE, LLEWELLYN V, WAMEGO
BORRA, MARIO J, HUTCHINSON
BOS, NORMAN C, HUTCHINSON
BOSILEVAC, FREO N, KANSAS CITY
BOSILJEVAC JR, JOSEPH E, EMPORIA
BOSSE, FRANK K, ATCHISON

* Probationary members.

BOSSEMEYER II, CHARLES H, OSAWATOMIE
BOTTERON, KELLY N, KANSAS CITY
BOTTS, LARRY D, SHAWNEE MISSION
BOUDA, DAVID W, HUTCHINSON
BOUDREAUX, VELTIN J, HALSTEAD
BOWEN, CLOVIS W, TOPEKA
BOWEN JR, HARRY J, TOPEKA
*BOXBERGER, GREGORY R, WICHITA
BOYD, HAROLD D, KANSAS CITY
BOYD, SPENCER H, TOPEKA
BOYD, Z REX, WICHITA
BOYDEN, MARY S, LAWRENCE
BOYER, ROBERT E, KINGMAN
BOYLE, HUGH H, WICHITA
BRACKETT JR, CHARLES E, KANSAS CITY
BRADA, DONALD ROBERT, HUTCHINSON
BRADEN, BILL L, WAMEGO
BRADLEY, H RUSSELL, EMPORIA
BRADLEY, J RODERICK, GREENSBURG
BRADY, PETER A, KANSAS CITY
BRAHMAN, HERBERT D, TOPEKA
BRAKE, DAVID, WICHITA
BRANDSTED, ERNEST C, MCPHERSON
BRANIECKI, MARYLEE A, KANSAS CITY
BRANSON, VERNON L, LAWRENCE
BRAUN, EDWARD W, FORT SCOTT
BRAUN, KENNETH, WICHITA
BRAUN, ROBERT W, TOPEKA
BRAUN, STEVEN D, KANSAS CITY
BRAUN, THOMAS G, WICHITA
BRAUN, WILLIAM T, PORT ORANGE,FL
BRAUN III, WILLIAM T, WICHITA
BRAVERMAN, DAVID ELLIOTT, SHAWNEE MISSION
BRAY, AVIS PAGE, CONCORDIA
BRECKBILL, DAVID L, WICHITA
BRENNEIS, ANN T, WICHITA
BRETHOUR, LESLIE J, JUNCTION CITY
BREWER, MARSHALL A, ULYSSES
BRIAN, ROBERT M, EL DORADO
BRIDGENS, JAMES G, KANSAS CITY,MO
BRIDWELL, RUSSELL E, TOPEKA
BRILLHART, MAXINE T, KANSAS CITY
BRINTON, E HOLMES, WICHITA
BRINTON, EDWARD S, WICHITA
BRITO, RAUL E, WICHITA
BROCKHOUSE, JOHN P, EMPORIA
BRODKER, ROBERT M, SANTA BARBARA,CA
BROOKS, WILLIAM HENRY, SHAWNEE MISSION
BROSIUS, FRANK C, WICHITA
BROUCEK, FRANCIS J, SHAWNEE MISSION
BROWN, ALEX L, CLEARWATER,FL
BROWN, C EVERETT, STAFFORD
BROWN, DAVID J, WICHITA
BROWN, FRED E, ST MARYS
BROWN, JEFFERY C, SHAWNEE MISSION
BROWN, MICHAEL P, WICHITA
BROWN, MICHELLE R, WICHITA
BROWN, PAUL W, OLATHE
BROWN, ROBERT L, WICHITA
BROWN, ROBERT L, KANSAS CITY
BROWN, ROBERT M, MANHATTAN
BROWN, ROBERT D, RUSHVILLE,MO
BROWN, ROBERT WAYNE, SALINA
BROWN, RONALD C, WICHITA
BROWN, RONALD L, WICHITA
BROWN, VAL J, WICHITA
BROWN, WILLIAM R, SHAWNEE MISSION
BROWN JR, VAL J, WICHITA
BROWN-SANDERS, CAROLINE, LEES SUMMIT,MO
BROWNING, JIMMIE L, COTTONWOOD FALS
BROWNING, WILLIAM H, WICHITA
BROWNING, WILLIAM R, MADISON
BROWNRIGG, RICHARD L, DODGE CITY
BROXTERMAN, STEVEN JOSEPH, SHAWNEE MISSION
BRUMMETT, RICHARD R, SALINA
BRUNER JR, KENNETH W, SHAWNEE MISSION
BRUNFELDT, JOAN KRAUS, LAWRENCE
BRUNGARDT, BERNARD A, SALINA
BRUNING, ROGER MARION, SHAWNEE MISSION
BRUND, JAMES W, GARDEN CITY
BRYAN, EMERY C, ERIE
BRYANT, EUGENE A, HUTCHINSON
BRYANT, R KEVIN, CLAY CENTER
BUBB, STEPHEN K, KANSAS CITY
BUBECK, RALPH W, WICHITA
BUCK JR, BEN H, WICHITA
BUCK JR, HENRY W, LAWRENCE
BUCK JR, WILLIAM D, SHAWNEE MISSION
BUCKMAN, MARTIN SPALDING, SHAWNEE MISSION
BUDETTI, JOSEPH A, N MIAMI BEACH,FL
BUESING, OLIVER R, LEAVENWORTH
BUHR, BRUCE R, SHAWNEE MISSION
BULA, RALPH E, HAYS
BULLER, DAVID L, WICHITA
BUNDGARD, PETER A, SALINA
BUNKER JR, HERBERT L, JUNCTION CITY
BURDICK, BRUCE M, MANHATTAN
BURGER, J DALE, HUTCHINSON
BURGER, PAUL B, SHAWNEE MISSION
BURGER, WILLIAM E, BASEHOR
BURGESON, FRANK G, EMPORIA
BURGESS, ARTHUR P, OSWEGO
BURKE, JAMES J, FORT SCOTT
BURKE, JOSEPH V, ATCHISON
BURKET JR, GEORGE E, KINGMAN
BURKMAN, REUBEN J, CHANUTE
BURNETT, A DEAN, HALSTEAD
BURNEY, WILLIAM W, WICHITA
BURNEY II, WILLIAM W, WICHITA
BURPEE, JAMES F, WICHITA

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BURRESS, FRED J, KANSAS CITY
BURT, RONALD J, WICHITA
BUSCH, ANTHONY B, DODGE CITY
BUSKIRK, STEVEN J, TOPEKA
BUSTOS, JONAS G, HERINGTON
BUTCHER, THOMAS P, EMPORIA
BUTH, DENNIS K, WICHITA
BUTIN, J WALKER, WICHITA
BUTIN, RICHARD E, CLEVELAND,OH
BUTLER, DORIS C, WICHITA
BUTT, MUHAMMAD, CONCORDIA
BUTTERFIELD, MARI ANNE, KANSAS CITY
BYERS, JONELL, SALINA
BYERS, MARTHA S, KANSAS CITY
BYRNE, JAMES PERRY, WICHITA

C

CABRERA, ALBERTO, ELKHART
CABRERA, NATIVIDAD R, ELKHART
CACHIA, RICHARD M, TOPEKA
CAEDO, CARMELITA D, LIBERAL
CALBECK, JOHN, GARDEN CITY
CALDERON, JAIME, KANSAS CITY
CALIENDO JR, DANIEL J, WICHITA
CALKINS, JOHN W, KANSAS CITY
CALKINS, LARRY L, SHAWNEE MISSION
CAMARATA, PAUL J, SHAWNEE MISSION
CAMERON, JULIE F, KANSAS CITY
CAMERON, WILLIAM J, KANSAS CITY
CAMPBELL, EDWARD G, EMPORIA
CAMPBELL, FRANCES S, NEWTON
CAMPBELL, GARLAND L, ARKANSAS CITY
CAMPBELL, WILLIAM H, COFFEYVILLE
*CAMPION, MARY K, WICHITA
CAMPION, WOODROW M, LIBERAL
CANNATA, GENE, GREENSBURG
CANNON, DONALD C, WICHITA
CANNON, MICHAEL W, WICHITA
CAPPER, STANLEY L, WICHITA
CARDUFF, JAY J, DALLAS,TX
CAREY, LARRY J, PARSONS
CARLIN, JAMES WILLARD, KANSAS CITY
CARLSON, EARL V, HAYS
CARLSON, TERRY S, WICHITA
CARPENTER, PAUL R, KANSAS CITY
CARPER, IVAN H, NEWTON
CARPER, OWEN E, NEWTON
CARREAU, ERNEST P, CEDAREDGE,CO
CARRIAGA, MARISA T, SHAWNEE MISSION
CARRO, F AURELIO, WINFIELD
CARRO, TONY L, WESTMORELAND
CARTER, MACK A, FALL RIVER
CARTY, RUSSEL W, KANSAS CITY
CASEY, JAMES, HUTCHINSON
CASHMAN JR, MAURICE R, TOPEKA
CASTEEL, CHARLES K, SHAWNEE MISSION
CASTEEN, JOHN A, KANSAS CITY
CASTELLANI, SAM, WICHITA
CASTERLINE, JOHN B, WICHITA
CATHCART-RAKE, WILLIAM F, SALINA
CATHEY, ROBERT H, MANHATTAN
CATO, TERI A, WICHITA
CATTANEO, ERNEST A, SHAWNEE MISSION
CAUBLE, WILBUR G, WICHITA
CAUGHLIN, GERALD MICHAEL, WICHITA
CAVANAUGH, CLAIR J, GREAT BEND
CAVANAUGH, TIMOTHY B, KANSAS CITY
CAVITT, ROBERT F, SHAWNEE MISSION
CAWLEY, LEO P, WICHITA
CECIL III, JOHN, HAYS
CEDERLIND, CRANSTON JAY, SHAWNEE MISSION
CENAC, MARK T, LEAVENWORTH
CESSNA, JAMES E, PARADISE VALLEY, AZ
CHAFFEE, DEAN C, ABILENE
CHALABI, PHILLIP M, SHAWNEE MISSION
CHALIAN, ALEXANDER R, KANSAS CITY
CHAMBERLIN JR, CECIL R, TOPEKA
CHANEY, ERNIE J, WICHITA
CHANG, C H JOSEPH, KANSAS CITY
CHANG, FREDERIC C, WICHITA
CHANG, SHU FANG, SHAWNEE MISSION
CHAPMAN, JAMES H, WICHITA
CHAPPUIE, WILLIAM G, INDEPENDENCE
CHARD, FREDERICK H, WICHITA
CHATMAN, IRA DOUGLAS, WICHITA
CHEDIAK, ELIAS, LAWRENCE
CHEN, CHU-CHI, TOPEKA
CHEN, TAK-MING, TOPEKA
CHENG, MEI Y, KANSAS CITY
CHERRY JR, ARTHUR C, TOPEKA
CHERVEN, PHILIP L, HUTCHINSON
CHI, IL-SUNG, WICHITA
CHIN, CRAIGHTON, KANSAS CITY
CHIN, TOM D, KANSAS CITY
CHO, CHENG T, KANSAS CITY
CHO, SECHIN, WICHITA
CHONKO, ARNOLD M, KANSAS CITY
CHOPRA, RAMAN, WICHITA
CHOTIMONGKOL, ANUPONG, DODGE CITY
CHOW, STANLEY Y, FORT SCOTT
CHOY, JAMES K L, SUN CITY,AZ
CHRISTENSEN, MARION D, KIOWA
CHRISTENSEN, SHANE R, KANSAS CITY,MO
CHRISTMAN JR, CARL, WICHITA
CHRONISTER, BERT, NEODESHA
CHUBB, RICHARD M, BAXTER SPRINGS
CHUNG, JOHN J, SHARON SPRINGS
CISKEY, WILLIAM J, EUREKA
CLAASSEN, MILTON A, NEWTON
CLAASSEN, SAMUEL D, MCPHERSON
CLABOTS, JOSEPH P, KANSAS CITY
CLABOTS, M. TERESA, KANSAS CITY
CLARK, CHUCK, KANSAS CITY
CLARK, COURTNEY, WICHITA
CLARK, CRAIG N, TOPEKA
CLARK, DAVID H, SALINA
CLARK, LAURENCE A, WAMEGO
CLARK, ORVILLE R, ST PETERSBURG,FL
CLARK, PERRY L, KANSAS CITY
CLARK, RAY A, LAKE CHAS,LA
CLARK, ROBERT THOMAS, GUATEMALA CEN A,
CLAWSON, D KAY, KANSAS CITY
CLAY, MICHAEL J, KANSAS CITY,MO
CLENDENIN, ROBERT KEELE, SHAWNEE MISSION
CLIFTON, H DAVID, WICHITA
CLINE, BYRON W, WICHITA
CLINTON, DALE L, LAWRENCE
CLOYD, DAVID W, SHAWNEE MISSION
CLYMER, DAVID J, SHAWNEE MISSION
COADY, MARY ANN, KANSAS CITY
COALE, LLOYD H, KANSAS CITY
COBB, JEANNINE M, WICHITA
COBB, LESLIE H, MULVANE
COCHRAN, PAUL W, TOPEKA
CODY, DOROTHY, HAYS
CODY, JOHN, HAYS
COE, RICHARD D, SHAWNEE MISSION
COFFEY, ROY B, SALINA
COHEN, JUSTIN THOMAS, WICHITA
COHEN, LOUIS, TOPEKA
COHEN, MARC D, SHAWNEE MISSION
COHEN, ROBERT A, SHAWNEE MISSION
COHLMIA, JERRY B, WICHITA
COHN, L ELIZABETH, SHAWNEE MISSION
COHN, STEVEN G, SHAWNEE MISSION
COHNBERG, ROSELLEN E, CEDAR VALE
COKELEY, JOHN M, TOPEKA
COKER, W LAURENCE, TOPEKA
COKER JR, GRADY N, HUTCHINSON
COLDSMITH, DONALD C, EMPORIA
COLE, WARD M, WELLINGTON
COLEMAN, GARY, ABILENE
COLEMAN, ROBERT L, SHAWNEE MISSION
COLEMAN, THOMAS J, WICHITA
COLIP, F MERLYNN, NORTON
COLLIER, HAROLD W, WICHITA
COLLIER, WILLIAM J, MCPHERSON
COLLINS, DAVID E, KANSAS CITY
COLLINS, DEAN T, TOPEKA
COLLINS, EDWARD JOSEPH, TOPEKA
COLLINS, ELISABETH B, TOPEKA
COLLINS, FRANCIS T, TOPEKA
COLLINS, JEFFREY S, KANSAS CITY,MO
COLLINS, SHARON A, GARDEN CITY
COLYER, JEFFREY W, KANSAS CITY,MO
COMBS, PETER S, LEAVENWORTH
CONANT, FERRILL R, OLATHE
CONARD, CLAIR C, DODGE CITY
CONCANNON, CRAIG A, WICHITA
CONCEPCION JR, EUGENIO S, WICHITA
CONNELLY, MAURICE R, SALINA
CONNER, BRIAN, SALINA
CONRARDY, PETER A, WICHITA
CONROY, ROBERT W, TOPEKA
COOK, DONALD RAY, WICHITA
COOK, G EDWARD, WICHITA
COOK, JAMES D, KANSAS CITY
COOK, KAROLYN M, WICHITA
COOK, THEODORE R, WICHITA
COOKE, ALLAN R, KANSAS CITY
COOLEY, DAVID A, SHAWNEE MISSION
COOLEY, DENNIS M, TOPEKA
COOMER, TYLER E, PITTSBURG
COONFIELD, JAMES W, KANSAS CITY
COONROD, SCOTT A, SHAWNEE MISSION
COOPER, ARTHUR E, NORTON
COOPER, CATHY N, KANSAS CITY
COOPER, JACK R, SHAWNEE MISSION
COOPER, KENT J, PITTSBURG
COOPER, LEO F, DREXEL,MO
COOPER, M KENT, WICHITA
COPELAND, GARY A, JUNCTION CITY
COPENING, TELL B, IOLA
COPPLE JR, HAL E, TOPEKA
CORBIN, MURRAY D, SHAWNEE MISSION
CORDER, ROBERT L, ST JOSEPH,MO
CORDER, S SCOTT, OTTAWA
CORDRY, VINCEL R, D.O., WICHITA
CORNELL, EARL G, CONCORDIA
CORONADO, EDWARD H, WICHITA
COSSETTE, JERROLD E, SALINA
COSSMAN, F PRICE, WICHITA
COTTON, ROBERT T, TOPEKA
COULTER, HENRY F, SHAWNEE MISSION
COULTER, THOMAS B, SHAWNEE MISSION
COULTER, THAYNE A, D.O., CLYDE
COVERT, THOMAS J, SALINA
COVINGTON, CHRISTOPHER G, SHAWNEE MISSION
COWLES, GORDON T, WICHITA
COX, ROBERT H, HAYS
COX III, IRA L, KANSAS CITY
COX JR, IRA, SHAWNEE MISSION
COYLE, JOHN F, COFFEYVILLE
CRABB, JEREMIAH E, KANSAS CITY,MO
CRAIG, CHARLES C, NEWTON
CRAIG, THOMAS A, JUNCTION CITY
CRAM, ERNEST R, ST FRANCIS
CRAM JR, OLE R, LARNED
CRAMER, GUY W, PARSONS

CRAMM, RUSSELL E, HAYS
CRANE, CHARLES H, MANHATTAN
CRANE, DAVID D, WICHITA
CRARY, JOHN E, TOPEKA
CREEK, ALAN D, D.O., SHAWNEE MISSION
CRIDER, KAY _, TOPEKA
CROCKETT, CHARLES A, KANSAS CITY
CRONIN, DONALD J, WICHITA
CROUCH, STEVEN W, TOPEKA
CROUCH, WILLIAM H, TOPEKA
CROW, ERNEST W, WICHITA
CROW, JIMMIE R, SHAWNEE MISSION
CROWLEY, EDWARD X, WICHITA
CULP, LOUIS M, KANSAS CITY
CULTRON, FRANK T, SALINA
CULVER, WARREN T, LAWRENCE
CUMMINGS, RICHARD J, WICHITA
CURRAN, KEVIN E, SHAWNEE MISSION
CZAPANSKY, DESIREE K, WICHITA

D

D'SOUZA, BISMARCK C, SALINA
DADKHAH, NADER, KANSAS CITY
DAEHNKE, SIGURD S, WINFIELD
DAHL, ASHER W, COLBY
DAIZ, ANTONIO S, PARSONS
DAKHIL, SHAKER R, WICHITA
DALUM, PETER JOSEPH, CLAY CENTER
DANBY, JOHN H, WICHITA
DANIELS, PATRICIA W, SHAWNEE MISSION
DANIELS, ROBERT M, VALLEY CENTER
DANSDILL, DAVID J, WICHITA
DARR, RICHARD B, KANSAS CITY
DARRAH, JOY N, WICHITA
DAVIDNER, MARK L, KANSAS CITY, MO
DAVIDSON, HARRY T, WICHITA
DAVIS, BRADLEY E, SHAWNEE MISSION
DAVIS, CHESTER R, TOPEKA
DAVIS, CHRISTOPHER G, KANSAS CITY
*DAVIS, DANIEL R, WICHITA
DAVIS, DAVID H, LARNED
DAVIS, DAVID R, EMPORIA
DAVIS, GEORGE R, ELLSWORTH
DAVIS, PAUL H, WICHITA
DAVIS, RICHARD E, SHAWNEE MISSION
DAVIS, RONALD B, WICHITA
DAVIS, WILLIAM D, HUTCHINSON
*DAVISON, JOE D, WICHITA
DAY, HOWARD, WICHITA
DAY, HUGHES W, KANSAS CITY
DE BAKKER, JAN B, WICHITA
DE HART, ARTHUR DONIVA, WICHITA
DE JONG, JOHN THEODORE, KANSAS CITY, MO
DE LAPP, DENNIS K, N KANSAS CITY, MO
DE SMET, ARTHUR AUGUST, KANSAS CITY
DE SOUZA, DERRICK J, LEAVENWORTH
DE VRIES, PIETER A, KANSAS CITY
DE WITT, BARBARA L, KANSAS CITY
DEAY, CHARLES J, SHAWNEE MISSION
DECENA, IMMACULADA, LEAVENWORTH
DECHAIRD, THOMAS, WESTMORELAND
DECKER, DONALD D, HALSTEAD
DEGNER, JAMES B, GREAT BEND
DEGNER, JAMES C, WICHITA
DEITZ, MICHAEL R, KANSAS CITY
DEJONG, DAVID C, WICHITA
DELGADO, SERGIO, TOPEKA
DELLETT, KENNETH B, EL DORADO
DELMORE, JAMES E, HOUSTON, TX
DELP, MAHLON H, SHAWNEE MISSION
DELPHIA, ROBERT E, OLATHE
DELWORTH, MARK G, KANSAS CITY
DEMOSS, ELEANOR P, WICHITA
DENISON, TERRY R, SHAWNEE MISSION
DENNIS, DAVID T, MCPHERSON
DEPENBUSCH, FRANCIS L, HUTCHINSON
DERRINGTON, KENNETH L, SHAWNEE MISSION
DESOIGNIE, RAFAEL R, TOPEKA
DETAR, GEORGE F, IOLA
DETAR NEWBERT, LE ANNE, BONNER SPRINGS
DEVINS, GEORGE S, KANSAS CITY, MO
DEWBERRY JR, GLENN P, KANSAS CITY
DIACON, JAMES L, BELLA VISTA, AR
DIALLO, GASTON I, KANSAS CITY
DIAZ, ODLORES M, WICHITA
DIAZ, SALVADOR F, WICHITA
DICK, ARTHUR R, KANSAS CITY
DICK, WILLIS G, IOLA
DICK JR, HENRY J, EMPORIA
DICKINSON, CHARLES R, COFFEYVILLE
DIEDERICH, DENNIS A, KANSAS CITY
DIEHL, ANTONI M, KANSAS CITY, MO
DIENER, CLAYTON H, HESSTON
DILL, RODNEY, ATWOOD
DILLON, STEVEN C, PRATT
DILLON, WILLIAM L, PARSONS
DINGES, DAVID L, KANSAS CITY, MO
DION, MARK WM, ASHLAND
DIRKSEN, HANS C, WICHITA
DIXON, RAYMOND W, COFFEYVILLE
DO, SON T, KANSAS CITY, MO
DOBRATZ, ROBERT A, BELOIT
DOCKHORN, ROBERT J, SHAWNEE MISSION
DOEBLIN, P LAURENCE, WICHITA
DOERRY, KAREN E, MANHATTAN
DOHERTY, WILLIAM R, SHAWNEE MISSION

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DOLAN JR, PHILIP JARVIS, WICHITA
DONATELLE, EDWARD P, WICHITA
DONLEY, JAMES L, WICHITA
DONNELL, JAMES M, WICHITA
DONNELLY, WM PATRICK, GARDEN CITY
DORNBOS, J FRED, WICHITA
DORNHOFFER, JOHN L, KANSAS CITY
DORSCH, JOHN N, HAYS
DOUBEK, DEBBIE L, KANSAS CITY
DOUBEK, HERBERT D, BELLEVILLE
DOUGHERTY, THOMAS M, GARNETT
DOUGHERTY JR, THOMAS M P, WICHITA
DOUTHIT, DOUGLAS DAVID, WICHITA
DOWELL, JAMES C, SALINA
DOWNARD, JAMES M, SHAWNEE MISSION
DOZIER, FRED S, HERINGTON
DRAEMEL, H RICHARD, SALINA
DRAKE, CYNTHIA, SHAWNEE MISSION
DRAKE, DOUGLAS J, BELOIT
DRAKE, RALPH L, WICHITA
DRAZEK, GEORGE, WICHITA
DREHER, HENRY S, SALINA
DREILING, ROGER J, SHAWNEE MISSION
DREVETS, CURTIS C, WICHITA
DUCKETT, THOMAS G, HIAWATHA
DUCKETT II, THOMAS G, SHAWNEE MISSION
DUENSING, KENNETH L, O.D., BLUE RAPIDS
DUGAN, DAVID L, WICHITA
DUHON, JOHN MARQUE, HUTCHINSON
DUICK, GREGORY, WICHITA
DUJOVNE, CARLOS A, KANSAS CITY
DULIN, JOSE I, KANSAS CITY
DUNAGIN, JACK A, TOPEKA
DUNCAN, KIRK A, N KANSAS CITY, MO
DUNIVEN, PHILIP L, TOPEKA
DUNLAP, MICHAEL O, ATCHISON
DUNLAP, RICHARD L, LAWRENCE
DUNN, DANIEL R, SCOTT CITY
DUNN, MARVIN I, KANSAS CITY
DUNSHEE, CARLYLE M, FORT SCOTT
DUNSHEE, CHERYL A, WICHITA
DURAND, ANTONIO C, WICHITA
DURKEE, WILLIAM R, MANHATTAN
DURST JR, ROBERT O, TOPEKA
DUYSAK, SAMI, LEAVENWORTH
DYCK, ARTHUR H, MCPHERSON
DYCK, ERIC LEE, HAYS
DYCK, GEORGE, NEWTON
DYER, VERNON E, WICHITA
DYSART, JACK C, STERLING

E

EASTES, GARY DEAN, HALSTEAD
EATON, EDWARD L, TOPEKA
EATON, GLEN E, SALINA
EATON, LESLIE F, SALINA
ECK, MARCI J, WICHITA
ECKART, DE MERLE E, HUTCHINSON
ECKERT, WILLIAM G, WICHITA
EODY, VICTOR M, HAYS
EDMONDS, MARTA J, TOPEKA
EDRDZO, M LUZ LUNA, COFFEYVILLE
EDWAROS, DAVID J, EMPORIA
EDWAROS, KIMBERLY K, SHAWNEE MISSION
EDWARDS, MANIS C, WICHITA
EDWARDS, SHELLEY J, KANSAS CITY
EGBERT, ANNE MARSH, WICHITA
EGEA, FERNANDO M, KANSAS CITY
EGELHOF, RICHARD H, WICHITA
EHLY, CHRISTOPHER J, KANSAS CITY, MO
EICHHORN, FRANK O, GARDEN CITY
EIDT, DAVID W, OLATHE
EIDT, LAURENCE A, OLATHE
EISEMANN, ALLAN D, KANSAS CITY
EISENHUT, RANDY E, OLATHE
ELANGOVAN, SUDHA, WICHITA
ELCOCK, DAVID G, SHAWNEE MISSION
ELDER, DOUGLAS M, TOPEKA
ELLIS, BOBBY J, EMPORIA
ELLIS, HARVEY D, WICHITA
ELLIS, LAVELLE A, WICHITA
ELLISON, PAUL O, SALINA
EMIG, MARK D, KANSAS CITY, MO
EMPSON, CHARLES L, INDEPENDENCE
ENDERS, WRAY, SHAWNEE MISSION
ENGELKEN, SUSAN F, ONAGA
ENNS, EUGENE K, NEWTON
ENNS, JAMES H, LAKE HAVASU CTY, AZ
ENOCH, ROLLAND, WICHITA
ENS, GERHARD GEORGE, HILLSBORO
ENS, PETER D, HILLSBORO
EPLEE, JOHN R, ATCHISON
ERBACHER, GEORGE E, O.D., ATWOOD
ERKEN, RONALD V, WICHITA
ERNST, R L, WICHITA
*ERNST, TARI MAE, WICHITA
ESCH, JOHN G, PITTSBURG
ESRIG, HAROLD L, O.D., SHAWNEE MISSION
ESTEP, THOMAS H, WICHITA
ESTES, NORMAN C, KANSAS CITY
ESTRADA, EDMUNDO C, LIBERAL
ESTRADA, LINA, LIBERAL
ETZENHOUSER III, RUSSELL D, SHAWNEE MISSION
EVANS, CAROL ANN, SHAWNEE MISSION
EVANS, FARRIS O, WICHITA
EVANS, GRANT E, WICHITA
EVANS, JOHN F, WICHITA
EVANS, RICHARD W, WICHITA
EVANS, ROGER WILLIAMS, WICHITA
EVANS, WILLIAM R, GREAT BEND
EVANS JR, WILLIAM E, SHAWNEE MISSION
EWING, THOMAS O, LARNED
EYSTER, ROBERT L, WICHITA

F

FABIAN, CAROL J, KANSAS CITY
FAILING, TRENT L, OLATHE
FAIRCHILD, JOHN A, MANHATTAN
FALTER, RICHARD T, HUTCHINSON
FANNING, JANET L, AUGUSTA
FANNING, KYLE W, AUGUSTA
FANSHIER, SHAWNETTE L, KANSAS CITY, MO
FARHA, GEORGE J, WICHITA
FARHA, S JIM, WICHITA
FARLEY, JAMES A, WICHITA
FARMER III, F J, D.O., STAFFORD
FARRIS, RONNIE S, EMPORIA
FAST, GARY A, KANSAS CITY
FAST, ROBERT E, ATCHISON
FAST, W SPENCER, ATCHISON
FEAGAN, JERRY, TOPEKA
*FEAREY, ALAN J, WICHITA
FEIGHNY, ROBERT E, SALINA
FELDMEYER, SEELEY T, MEADE
FENDER JR, THOMAS H, WICHITA
FENT, LEE S, NEWTON
FENTON, ROBERT M, GARDEN CITY
FERGUSON, BEVERLY J, KANSAS CITY
FERGUSON, ROBERT LEON, SHAWNEE MISSION
FERNANDEZ, HECTOR O, HOISINGTON
FERNANDEZ, LUIS A, TOPEKA
FERNANDEZ, MIGUEL A, TOPEKA
FERNIE, ROBERT W, BOULDER, CO
FERREE, RICHARD ALLAN, MCPHERSON
FERRELL, DONALD P, WICHITA
FERRIS, BRUCE G, WICHITA
FEUILLE JR, EDMOND G, WICHITA
FIELD, RICHARD A, TOPEKA
FIELDS, GALEN W, MCPHERSON
FIELDS, STEPHEN, O.D., WICHITA
FIESER, CARL W, GREAT BEND
FILLEY, VERNON W, PRATT
FILLMAN, ELDON M, TOPEKA
FINK, ABRAHAM A, PLANTATION, FL
FINLEY, DENNIS R, WICHITA
FISCHER, REX R, MANHATTAN
FISHER, JAMES B, WICHITA
FISHER, RAY F, WICHITA
FISHER, RONALD M, SCOTLAND,
FITZGERALD, EDWARD J, WICHITA
FITZIG, SANFORD, WICHITA
FITZPATRICK, M ROBERT, KANSAS CITY
FITZPATRICK, PAMELA S, KANSAS CITY
FLANDERS, H ALDEN, EDINBURGH, TX
FLANNER, FRANK R, HOISINGTON
FLECKENSTEIN, CHARLES S, ONAGA
FLEMING, FORNEY W, WICHITA
FLESKE, LEONARD T, GREAT BEND
FLOERSCH, HUBERT M, KANSAS CITY
FLOWERS JR, CLELL B, WICHITA
FLUTER, GEORGE G, KANSAS CITY
FLUTY, STEVEN R, SHAWNEE MISSION
FOGLEMAN, MILLARD L, OBERLIN
FORD, CHARLES R, WICHITA
FORD, FRED L, TOPEKA
FORDYCE, NORMAN, SHAWNEE MISSION
FORET, JOHN D, KANSAS CITY
FORSTER JR, LOUIS G, SALINA
FORTUNE, CEDRIC B, OLATHE
FOSS, DANIEL C, HUTCHINSON
FOSTER, D BERNARD, TOPEKA
FOSTER, FRANCES J, KANSAS CITY
FOWLER, DENNIS L, WINFIELD
FOWLER, ROBERT J, WICHITA
FOWLER, WAYNE L, CONCORDIA
FOX, DEANNA K, KANSAS CITY
FOX, HOWARD A, KANSAS CITY
FRANCIS, ANTHONY E, SALINA
FRANCIS, NORTON L, WICHITA
FRANCISCO, CLARENCE L, SHAWNEE MISSION
FRANCISCO, DAN A, WICHITA
FRANCISCO, EDGARDO, HORTON
FRANCISCO, LINDA L, WICHITA
FRANCISCO, W DAVID, KANSAS CITY
FRANK-GEIER, MARY S, SHAWNEE MISSION
FRANKEL, SCOTT J, SHAWNEE MISSION
FRANKLIN JR, BENJAMIN A, TOPEKA
FRANSEN, HERBERT, NEWTON
FRANSEN, PAUL H, NEWTON
FRECHETTE, ALAN R, KANSAS CITY, MO
FREDERICK, M F, HUGOTON
FREDRICKSON, DOREN D, KANSAS CITY
FREDRICKSON, DUANE E, LINDSBORG
FREEBORN JR, WARREN S, CLYDE
FREEMAN, F GILES, PRATT
FREEMAN, FRED A, MANHATTAN
FREEMAN, MALCOLM C, PITTSBURG
FREEMAN, RAYMOND S, SALINA
FRENCH, JAMES E, WICHITA

FRENCH, JEROME E, WICHITA
FRIESEN, DALE, LAWRENCE
FRIESEN, FLORENCE V, HESSTON
FRIESEN, ORLANDO J, BUHLER
FRIESEN, STANLEY R, KANSAS CITY
FRIESEN, SUSAN G, KANSAS CITY
FRIGGERI, ROBERT W, GIRARD
FRITZ, GEORGE E, KEWADIN,MI
FRITZEMEIER, WILLIAM H, WICHITA
FROMER, JOEL, WICHITA
FROMM, ARTHUR H, WICHITA
FROST, ELIZABETH L, KANSAS CITY
FRY, LUTHER L, GARDEN CITY
FUGATE, CARL L, WICHITA
FULLER, DERYL O, LINDSBORG
FULTON, JOHN K, WICHITA
FUNK, EDWARD O, LAWRENCE

G

GABRIELLI JR, WILLIAM F, KANSAS CITY
GAGE, BETSE M, SHAWNEE MISSION
GALBUT, ALAN S, SHAWNEE MISSION
GALICHIA, JOSEPH P, WICHITA
GALLEHUGH, KEITH W, SHAWNEE MISSION
GALLER, GREG WAYNE, KANSAS CITY
GALVAN, ALONSO, WICHITA
GANDHI, SHANTIKUMAR K, TOPEKA
GANN, E LAMONTE, EMPORIA
GANS, FREDERICK A, SALINA
GANZARAIN, RAMON C, TOPEKA
GARCIA, FRANCISCO, SHAWNEE MISSION
GARCIA, GOULD C, EMPORIA
GARCIA, GUILLERMO O, DODGE CITY
GARCIA-FERRER, CIRA M, SHAWNEE MISSION
GARD, RAYMOND F, WICHITA
GARD, RICHARD A, HUTCHINSON
GARDINER, ROBERT C, SHAWNEE MISSION
GARDINER, TED M, GARDEN CITY
GARDNER, BILLIE L, HARPER
GARDNER, GLENN M, SHAWNEE MISSION
GARDNER, JAMES D, MANHATTAN
GATENO, JOSEPH, GREAT BEND
GATSCHET, TIMOTHY P, SEDGWICK
GAUGHAN, MICHAEL J, SHAWNEE MISSION
GAUME, JAMES G, PALOS VERDES,CA
GAY, JOHN D, TOPEKA
GEARY, ALICE L, WICHITA
GEHRT, EARL B, CHANUTE
GEIER, DAVID L, SHAWNEE MISSION
GEIS, DICK A, TOPEKA
GEITZ, JAMES M, EMPORIA
GELVIN, E RAYMOND, CONCORDIA
GENCH, RAYMOND L, CARMEL,CA
GENDEL, JOSEPH E, TOPEKA
GENILO, AMANCIO C, WICHITA
GENILO, CELESTE A, WICHITA
GENTRY, JAMES H, DENVER,CO
GENTRY, KALE C, SHAWNEE MISSION
GEORGE, EARL F, WICHITA
GEORGE, M DON, WICHITA
GEORGE, PAULA Y, KANSAS CITY
GERBER, ALLEN D, WICHITA
GERBER, HARRY A, LEAVENWORTH
GERJARUSAK, PRAPAS, KANSAS CITY
GERRONO, LINDA L, SHAWNEE MISSION
GESSLER, DONALD J, HOUSTON,TX
GETTLER, DEAN T, FORT SCOTT
GIBBS, EUGENE, COFFEYVILLE
GIESSEL, MICHAEL D, TOPEKA
GILBERT, J HOWARD, SENECA
GILBERT, ROBERTA M, SHAWNEE MISSION
GILBERT II, JOHN H, GARDEN CITY
GILHOUSEN, FREDERIC M, KANSAS CITY
GILL, GEORGE L, LAMPE,MO
GILLEN, BILLY A, SHAWNEE MISSION
GILLENWATER, DAVID T, WICHITA
GILLES, HELEN M, LAWRENCE
GILLETT, MARK L, KANSAS CITY
GILMARTIN, RICHARD C, WICHITA
GIMPLE, KENNETH, TOPEKA
GINAVAN, DUANE A, EMPORIA
GIROD, CHARLES I, EL DORADO
GIRON JR, LOUIS T, KANSAS CITY
GIVNER, DAVID, WICHITA
GLATTER, THOMAS R, KANSAS CITY,MO
GLAZZARD, CHARLES D, OLATHE
GLEASON, JIMMIE A, TOPEKA
GLENN, JAMES N, EMPORIA
GLENN, LYLE G, PROTECTION
GLOTZBACH, ROBIN K, KANSAS CITY
GLOVER, RICHARD M, NEWTON
GLOVER II, RICHARD M, KANSAS CITY
GNAU, FREDRIC B, HALSTEAD
GODFREY, WILLIAM A, KANSAS CITY,MO
GODWIN, PHILLIP A, LAWRENCE
GOERING, DONALD D, COLDWATER
GOERING, EMIL L, TOPEKA
GOERING, RANDALL V, WICHITA
GOERTZ, KENNETH K, KANSAS CITY
GOERTZ, LEO R, KANSAS CITY
GOLDBERG, HERBERT R, WICHITA
GOLDBERG, JOHN M, KANSAS CITY
GOLDSTEIN, ALAN D, KANSAS CITY
GOLDSTEIN, GERALD L, SHAWNEE MISSION
GOLLERKERI, MOHAN P, SHAWNEE MISSION
GOLLIER II, ROBERT A, OTTAWA
GOLLUB, STEVEN B, KANSAS CITY
GOMETZ, MODESTO S, PITTSBURG
GOMEZ, FRANCISCO, SHAWNEE MISSION
GONTERO, ELIZABETH K M, KANSAS CITY
GONZALEZ, HIRAM, WICHITA
GOOD, JAMES T, FORT SCOTT
GOOD, MICHAEL W, CLAY CENTER
GOOD, WENDELL LISLE, SHAWNEE MISSION
GOODPASTURE, HEWITT C, WICHITA
GOODPASTURE, WILLARD C, GREEN VALLEY,AZ
GOODWIN, DONALD W, KANSAS CITY
GOODWIN, JOHN A, KANSAS CITY
GOODWIN, MARY K, ANDALE
GORDON, JAMES R, WICHITA
GORMAN, JAMES W, KANSAS CITY
GORTON, MICHAEL E, WICHITA
GOSALIA, ANIL V, SHAWNEE MISSION
GOTO, HIROSHI, KANSAS CITY
GOYLE, KRISHAN K, WICHITA
GOYLE, VIMAL, WICHITA
GRABAU, GUY M, KANSAS CITY
GRABER, CHARLES, NEWTON
GRADY, KENNETH L, KANSAS CITY
GRAHAM, KENNETH L, LEAVENWORTH
GRAHAM, THOMAS W, LEAVENWORTH
GRAHAM, WALLACE H, KANSAS CITY,MO
GRAHAM JR, CHARLES P, TOPEKA
GRANT, MICHAEL D, CONCORDIA
GRANTHAM, HERBERT G, FORT SCOTT
GRANTHAM, JAREO J, KANSAS CITY
GRASHOFF, JOYCE A, SHAWNEE MISSION
GRATNY, LINDA L, LEAVENWORTH
GRAUEL, CHARLES W, WICHITA
GRAVES, JACK W, WICHITA
GRAVES, KATHRYN, HUTCHINSON
GRAY, C LUCIEN, WICHITA
GRAY, DAVID E, TOPEKA
GRAY, H TOM, WICHITA
GRAY, SCOTT E, LAWRENCE
GRAYIB, ANTOINE S, TOPEKA
GREENBERG, CRAIG P, WICHITA
GREENBERG, GEORGE E, DODGE CITY
GREENBERG, MARK, TOPEKA
GREENBERGER, N J, KANSAS CITY
GREENE, HORACE T, TOPEKA
GREENE, LAWRENCE S, SHAWNEE MISSION
GREENE, RUSSELL E, TOPEKA
GREENWOOD, EDWARD D, TOPEKA
GREENWOOD, JAMES F, GARDEN CITY
GREENWOOD, JOHN M, KANSAS CITY
GREENWOOD, MELANIE A, WICHITA
GREER, JAMES A, WICHITA
GREER, RICHARD H, TOPEKA
GRELINGER, BART A, WICHITA
*GRENE, ROBERT BRUCE, WICHITA
GRIBBLE, ROBERT N, WICHITA
GRIESHABER, GORDON J, SHAWNEE MISSION
GRIFFING, RICHARD B, SALINA
GRIFFITH, FRANK H, SALINA
GRILLOT, FLOYD B, WICHITA
GRILLOT, MICHAEL B, KANSAS CITY
GRIMALDI, GARY A, FORT SCOTT
GRIMES, I ROSS, LIBERAL
GRIMES, JAMES T, LYONS
GRISOLIA, ANDRES, LEAVENWORTH
GRISWOLD, DALE G, NEWTON
GROHS, HEINZ K, WICHITA
GROSSMAN, HARVEY M, SHAWNEE MISSION
GROSWALD, DOUGLAS E, KANSAS CITY
GROWNEY, JOHN T, ATCHISON
GRUENDEL, RICHARD A, KANSAS CITY
GRUENDEL, VIRGINIA T, KANSAS CITY
GRUNDMEIER, ANNETTE M, SHAWNEE MISSION
GRUSHNYS, ARNOLD, WICHITA
GSELL, GEORGE F, WICHITA
GUARDIA, DAVID K, KANSAS CITY
GUASTELLO, MARIO J, KANSAS CITY,MO
GUDEMAN, DAVID M, KANSAS CITY
GUMUCIO, MARIO L, KANSAS CITY
GUNN, MARVIN R, SALINA
GUTHRIE, RICHARD A, WICHITA
GUTOVITZ, ALLEN LOUIS, TOPEKA
GUTTIKONDA, PRASAD B, YOUNGSTOWN,OH
GUZMAN, MANUEL, SALINA

H

HA, SANG W, COFFEYVILLE
HABASHY, SHAWKY N F, WICHITA
HACKER, DAVID CHARLES, SHAWNEE MISSION
HACKER, ELAINE MARY, TOPEKA
HADLEY, DELMONT C, OTTAWA
HAFFNER, WILLIAM N, EL DORADO
HAGAN, C THOMAS, WICHITA
HAGAN, FRANCIS J, WICHITA
HAGAN, ROBERT C, WICHITA
*HAGAN, STEPHEN F, WICHITA
HAGGAN, MARGARET E, LAWRENCE
HAGMAN, JENNIFER D, KANSAS CITY,MO
HAIGLER, JAMES P, HAYS
HAIRE, WILLIAM D, HALSTEAD
HALE, RALPH, WICHITA
HALL, GARY D, SHAWNEE MISSION
HALL, J ROGER, WICHITA
HALL, WESLEY H, GIRARD
HALL III, THOMAS BRYAN, KANSAS CITY
HALL JR, ERNEST B, HIAWATHA
HALLEY, M MARTIN, TOPEKA
HALLING, L WILLIAM, HAYS
HALPIN, EDWARD D, WICHITA
HALVORSON, HOWARD C, OLATHE
HAM, ROBERT E, WICHITA
HAMILTON, JAMES J, WAKEENEY
HAMILTON, WILLIAM A, KANSAS CITY,MO
HAMM, ORVAL L, PAKISTAN,
HAMMEKE, JOHN C, LEAVENWORTH
HAMPEL, KEVIN G, KANSAS CITY
HAMTIL, LAWRENCE W, SHAWNEE MISSION
HAN, CHAN S, COFFEYVILLE
HANCOCK, ALAN C, KANSAS CITY
HANCOCK, DANIEL E, MANHATTAN
HANDLEY, DENNIS MICHAEL, SHAWNEE MISSION
HANOS, SEBEL V, AMARILLO,TX
HANDSHY, STANLEY E, ERIE
HANSEN, DANIELS D, HAMET,CA
HANSEN, FRANK W, GARDEN CITY
HANSON, DAVID C, HUTCHINSON
HANSON, FREDERICK, KANSAS CITY
HANSON, ROBERT L, WICHITA
HARA, GLENN S, KANSAS CITY
HARBIN, GARY LYNN, SALINA
HARD, BENJAMIN F, KANSAS CITY,MO
HARDIN, CREIGHTON A, KANSAS CITY
HAROTEN, DAVID R, KANSAS CITY
HARMON, GARY S, SHAWNEE MISSION
HARMS, ALBERT C, SHAWNEE MISSION
HARMS, EDWIN M, WICHITA
HARMS, WILMER A, HALSTEAD
HARPER, DIANE M, KANSAS CITY
HARPSTER, GENE D, SHAWNEE MISSION
HARRIS, FRANK H, WICHITA
HARRIS, HUBERT L, TOPEKA
HARRIS, NORMAN R, SALINA
HARRIS, NORVAN D, LIBERAL
HARRIS, PATRICIA A, TOPEKA
HARRIS JR, CLAIB B, GARNETT
HARRISON, HALL E, TOPEKA
HARRISON, PAUL BARRY, WICHITA
HARSTINE, LILLIAN R, WICHITA
HART, DILLIS L, WICHITA
HART, JOHN J, WICHITA
HART, KELLY Z, KANSAS CITY
HART, LAWRENCE E, ATCHISON
HARTLEY, FOUNT K, GAINESVILLE,FL
HARTLEY, JAMES M, WICHITA
HARTLEY, ROY W, NORTON
HARTMAN, CHARLES R, KANSAS CITY
HARTMAN, GERALD V, KANSAS CITY
HARTMAN, ROGER L, NORTON
HARTONG, TOBY JOSEPH, SHAWNEE MISSION
HARTONG, WILLIAM A, SHAWNEE MISSION
HARTWELL, RICK L, WICHITA
HARTY, JEAN R, SHAWNEE MISSION
HARVEY, JEAN A, DALLAS,TX
HARVEY, JOHN E, EMPORIA
HARVEY, R CLAY, TOPEKA
HARVEY, ROSEMARY B, WICHITA
HARWOOD, CLAUDE J, GLASCO
HASAN, SANJIDA, WICHITA
HASKINS, ROBERT J, CHANUTE
HASSAN, RIZWAN U, WICHITA
HASSELLE III, JAMES E, LAWRENCE
HASSETT, GERARD R, COLBY
HASSLER, RANDY D, SALINA
HATESOHL, STANLEY M, LINN
HATHAWAY, PETER, SHAWNEE MISSION
HATTON, DONALD W, LAWRENCE
HATTON, LLOYD W, SALINA
HATTRUP, RICHARD J, WICHITA
HAUN, RUDY T, MANHATTAN
HAVENHILL II, MARSHALL A, EMPORIA
HAWLEY, RAYMOND G, WICHITA
HAY, JAMES R, SHAWNEE MISSION
HAYES, DAVID M, KANSAS CITY,MO
HAYES, J EDWARD, BOISE,ID
HAYES, WILLIAM L, WICHITA
HAYNES, DEBORAH G, WICHITA
HAYS, THOMAS H, WICHITA
HEADRICK, DANIEL E, WICHITA
HEASTY, ROBERT G, MANHATTAN
HEBBAR, SATYA N, TOPEKA
HEDDEN, RICHARD J, SHAWNEE MISSION
HEDRICK, KENNETH E, HUTCHINSON
*HEEB, CAMILE, TOPEKA
HEIM, MARY LEE, KANSAS CITY,MO
HELENA, WESLEY D, KANSAS CITY
HELLMAN, DAVID W, WICHITA
HENDERSON, CHARLES F, PARSONS
HENDERSON, DAVID V, GARNETT
HENDRICKS, WILLIAM J, SHAWNEE MISSION
HENDRICKSON, JON R, NEWTON
HENDRICKSON, KATHRYN D, NEWTON
HENKE, JEFFREY L, KANSAS CITY
HENNING, CALVIN W, OTTAWA
HENNING, CHARLES E, WICHITA
HENNING JR, HAROLD JOHN, KANSAS CITY
HENRY, JOSEPH E, SHAWNEE MISSION
HENSON, STEVEN R, HESSTON
HERED, JOHN, WICHITA
HERMES, RICHARD L, LAWRENCE
HERMRECK, ARLO S, KANSAS CITY
HERRERA, JORGE J, TOPEKA
HERRMAN, ADAM L, SALINA
HERRON, KRISTINE G, SHAWNEE MISSION
*HERSHBERGER, RAY E, WICHITA
HERSHBERGER, GROVER, O,D,, WICHITA
HERSHORN, SIMON E, WICHITA
HESSER, HERBERT H, SHAWNEE MISSION
*HETT, EDWARD J, WICHITA
HETTINGER, MICHAEL E, SHAWNEE MISSION
HICKMAN, JAMES STEPHEN, TOPEKA

* Probationary members.

HIEBERT, ABRAHAM E, WICHITA
HIEBERT, DAVID L, LAWRENCE
HIEBERT, JOHN B, TOPEKA
HIEBERT, JOHN M, KANSAS CITY
HIESTERMAN, HERMAN W, QUINTER
HILDYARD II, VICTOR H, COLBY
HILL, JAMES E, ARKANSAS CITY
HILL, LARY MICHAEL, GREAT BEND
HILL, RICHARD H, MEADE
HILL, ROBERT N, TOPEKA
HILL, RODNEY W, SHAWNEE MISSION
HILST, WILBUR O, TOPEKA
*HINKIN, DOUGLAS P, MANHATTAN
HINMAN, MARK W, SHAWNEE MISSION
HINSHAW, ALFRED H, WICHITA
HINSHAW, CHARLES T, WICHITA
HINSHAW, EDGAR O, ARKANSAS CITY
HINSHAW JR, CHARLES T, WICHITA
HINTHORN, DANIEL R, KANSAS CITY
HIRATZKA, TOMIHARU, WICHITA
HIRSCHBERG, J COTTER, TOPEKA
HISZCZYNSKYJ, ROMAN, TOPEKA
HITCHCOCK, C THOMAS, SHAWNEE MISSION
HIZON, RAMON R, WICHITA
HOADLEY, WILLIAM O, KANSAS CITY
HOBBS, DONALD D, TOPEKA
HOBSON, MILBURN W, SHAWNEE MISSION
HODES, HERBERT C, SHAWNEE MISSION
HODGES, BRUCE E, SHAWNEE MISSION
HODGES, GLENN R, KANSAS CITY
HODGES, MERLE A, SALINA
HODGSON, DAVID K, WASHINGTON
HODGSON, JAMES F, KANSAS CITY
HODSON, HERVEY R, WICHITA
HOFER, DEWAYNE O, CONCORDIA
HOFFER, JOHN G, MEDICINE LODGE
*HOFFMAN, JAMES E, WICHITA
HOHERZ, DAVID G, TOPEKA
HOHLY, EVE K, KANSAS CITY,MO
HOLCOMB, DONALD G, LOS ANGELES,CA
HOLCOMB, WILLIAM M, LIBERAL
HOLDCRAFT, JACQUELYNE, KANSAS CITY
HOLDEN, JILL K, SHAWNEE MISSION
HOLDEN JR, RAYMOND F, WICHITA
HOLDERMAN, WALLACE O, HUTCHINSON
HOLLADAY, KENNETH R, EUDORA
HOLLAND JR, DAVID L, WICHITA
HOLLIS, KENNETH W, MATNEFIELD,ME
HOLMAN, JON B, SALINA
HOLMES, FREDERICK F, KANSAS CITY
HOLMES, GRACE E, KANSAS CITY
HOLMES, JEO, WICHITA
HOLMES, JOHN A, KANSAS CITY
HOLMES, ROBERT W, TOPEKA
HOLSINGER, DONALD M, PITTSBURG
HOLT, JOHN M, GREAT BEND
HON, DAVID E, WICHITA
HOOD, ROGER W, SHAWNEE MISSION
HOOFER, WILFORD D, HALSTEAD
HOPKINS, JAMES P, KANSAS CITY,MO
HOPKINS, LENLEY, SHAWNEE MISSION
HOPKINS, WILLIAM O, SHAWNEE MISSION
HOPKINS JR, B MORRISON, SCOTT CITY
HOPPER, CHARLES R, EMPORIA
HORBELT, DOUGLAS V, WICHITA
HORNE, JAMES B, TOPEKA
HORSEMAN, ROBERT F, SHAWNEE MISSION
HOSTETLER, ROBERT W, KANSAS CITY
HOSTETTER, JAMES P, TOPEKA
HOSTETTER, MARCIA MORGAN, TOPEKA
HOSTETTER, PHILIP H, MANHATTAN
HOURIGAN, RICHARD J, KANSAS CITY
HOUSHOLDER, DANIEL FAIR, WICHITA
HOUSHOLDER, MARTHA S, WICHITA
HOUSTON II, LAWRENCE MORLEY, SHAWNEE MISSION
HOWARD, DONALD O, WICHITA
HOWELL, BARBARA JOYCE, EMPORIA
HOWERTER JR, BERNARD E, COFFEYVILLE
HOYT, ARTHUR W, TOPEKA
HRABIK, BRENT A, SHAWNEE MISSION
HSU, CECILIA, SHAWNEE MISSION
HSU, CHENG H, TOPEKA
HSU, SHIN-FU, TOPEKA
HUAMAN, ANTONIO M, AL AIN,
HUANG, GEORGIANA L W, SHAWNEE MISSION
HUANG, JOHNSON, TOPEKA
HUDSON, ROBERT P, OLATHE
HUEBERT, DEAN A, WICHITA
HUEBNER, ROBERT STEPHAN, PITTSBURG
HUERTER, DAVID F, PITTSBURG
HUERTER, QUENTIN C, KANSAS CITY
HUGHES, ROBERT WALTER, LAWRENCE
HUGHES, STEVEN, KANSAS CITY,MO
HULL, KENNETH L, WICHITA
HULTGREN, MYRON K, WICHITA
HUME, JOSEPH W, WICHITA
HUMMER, LLOYD M, WICHITA
HUMPHREY, LOREN JENKINS, SHAWNEE MISSION
HUND, LARRY R, WICHITA
HUNKELER, JOHN D, SHAWNEE MISSION
HUNNINGHAKE, RONALD, SALINA
HUNSBERGER, TERRY R, D.O., GARDEN CITY
HUNTER, KENNETH R, LEBO
HUNTER JR, JAMES S, GREENVALLEY,AZ
HURLBUT, KEVIN M, KANSAS CITY
HURWITZ, ARYEH, KANSAS CITY
HURWITZ, MICHAEL A, HUTCHINSON
HUSEMAN, RICHARD ALLAN, NORTH KANS CITY,MO
HUSTEAD, ROBERT F, WICHITA
HUSTON, FRANCIS W, WINCHESTER
HUSTON, JOSEPH W, TOPEKA
HUTCHINSON, DIRK T, WINFIELD
HUTCHINSON, STEVEN A, WICHITA
HUTCHISON, GLEN C, HAYS
HUTCHISON, MARC K, HAYS
HUTCHISON, SCOT M, KANSAS CITY
HUTSEY, PAUL J, WICHITA
HUTTERER, ANGELA J, KANSAS CITY
HUTTON, FREDERICK A, TOPEKA
HWA, EUGENE C, NEWTON
HYLAND, JOSEPH M, TOPEKA
HYMAN, HENRY T, D.D., KANSAS CITY,MO
HYNES, HENRY E, WICHITA

I

IBARRA, J LUIS, WICHITA
IBARRA, RICHARD C, KANSAS CITY
IDBEIS, BADR, WICHITA
ILIFF, R DOUGLAS, TOPEKA
ILIOPOULOS, JOHN I, KANSAS CITY
ILORETA, ALFREDO T, TOPEKA
INGHAM JR, H LAIRD, LAWRENCE
INGRAM, JOHN E, KANSAS CITY
INNES, ROBERT C, SHAWNEE MISSION
IRBY, ADDISON C, FORT SCOTT
IRBY, PRATT, FORT SCOTT
IRWIN, RICHARD L, NEWTON
ISAAC, CHARLES A, NEWTON
*ISAACS, JUANITA J, WICHITA
ISAACSON, RICHARD N, TOPEKA
ISERN, HENRY J, KANSAS CITY
ITURRALDE, GEORGE, SHAWNEE MISSION
IWAY, BELIND O, ELKHART
IWAY, OLIVIA N, ELKHART

J

JABEL, JUVENAL T, SATANTA
JACKS, J WARREN, HAWASEE,AR
JACKSON, CHARLES R, WICHITA
JACKSON, MICHAEL D, GARDEN CITY
JACKSON, ROBERT V, SHAWNEE MISSION
JACKSON, ROGER P, KANSAS CITY,MO
JACKSON, VICTOR L, ALTAMONT
JACKSON JR, DELMAS A, SALINA
*JACKSON JR, DONALD H, TOPEKA
JACOB, KANNAMPALLY L, EL DORADO
JACOBS, DANIEL H, SHAWNEE MISSION
JACOBS, DAVID S, KANSAS CITY
JACOBS, RAE R, KANSAS CITY
JACOBSEN, DWIGHT SKINNER, COLBY
JACOBY II, ROBERT E, TOPEKA
JAEGER, MARY G, KANSAS CITY
JAHANIAN, DARYOUSH, KANSAS CITY
JAMBOR, CHRISTOPHER N, DODGE CITY
JAMES, DONALD L, WICHITA
JAMES, VERNON L, WICHITA
JANES, DONALD R, SHAWNEE MISSION
JANSSEN, ERWIN T, TOPEKA
JARRETT, JOHN B, HUTCHINSON
JAWADI, JAMEELA HUSAIN, WICHITA
JAYARAM, MARANDAPALLI R, KANSAS CITY
JAZAYERLI, NABIL, WICHITA
JEHAN, SAYED S, WICHITA
JENAB, JOHN, SHAWNEE MISSION
JENKINS, DE ANN R, KANSAS CITY
JENNEY, CHARLES B, WICHITA
JENSEN, DARAN L, WICHITA
JENSEN, THOMAS M, OLATHE
JESTER, SHELBY L, WICHITA
JEWELL, ROSS L, ST FRANCIS
JEWELL, WILLIAM R, KANSAS CITY
JIRICKO, MILOS, COFFEYVILLE
JOHNSON, BRUCE E, KANSAS CITY
JOHNSON, CAROL ANN, WICHITA
JOHNSON, CAROLYN K, WICHITA
JOHNSON, CYNDA A, KANSAS CITY
JOHNSON, GARY A, SHAWNEE MISSION
JOHNSON, GEORGE C, WICHITA
JOHNSON, HOWELL D, DODGE CITY
JOHNSON, J RICHARD, MCPHERSON
JOHNSON, JOHN E, KANSAS CITY
JOHNSON, KEITH A, SHAWNEE MISSION
*JOHNSON, MARGARET J, WICHITA
JOHNSON, PAUL D, LEAVENWORTH
JOHNSON, RANDLE C, HUTCHINSON
JOHNSON, RICHARD L, HUTCHINSON
JOHNSON, TERESA F, KANSAS CITY,MO
JOHNSON, THOMAS E, WICHITA
JONES, BARBARA, KANSAS CITY
JONES, CHARLES E, SHAWNEE MISSION
JONES, DAVID B, SHAWNEE MISSION
JONES, EDWARD L, GREAT BEND
JONES, FORREST H, COLUMBUS
JONES, H IVOR, SHAWNEE MISSION
JONES, H PENFIELD, LAWRENCE
JONES, ROONEY L, WICHITA
JONES, WILLIAM T, MANHATTAN
JONES JR, HERMAN H, KANSAS CITY
JORDAN, JANET C, KANSAS CITY
JOSEPH, BRIAN W, TOPEKA
JOSEPH, HOWARD F, LAWRENCE
JOSEPH, JAPHET G, WICHITA
JOSLIN, CHARLIE G, KANSAS CITY
JOSPEH, ROSE, LAWRENCE
JOSS, CHARLES S, TOPEKA
JOST, GARY D, WICHITA
JOUVENAT, NEIL C, SHAWNEE MISSION
JOYCE, G BERNARD, TOPEKA
JUBELT, HILBERT P, MANHATTAN
JUOILLA JR, FRANCISCO, WICHITA
JUSTICE IV, WILLIAM M, KANSAS CITY
JUSTUS, WILLIAM J, PLEASANTON

K

KADIAN, RAJESH S, SHAWNEE MISSION
KADISON, HERBERT I, WICHITA
KAGAN, STUART M, SHAWNEE MISSION
KAHRS, GREG, KANSAS CITY, MO
KALBAC, RICHARD W, GARDEN CITY
KALDOR, RICHARD H, MANHATTAN
KALIVAS, JAMES T, KANSAS CITY
KALIVAS, LINDA L, SHAWNEE MISSION
KANE JR, WILLIAM M, HAYS
KAROATZKE, E STANLEY, WICHITA
KAROATZKE, JON K, WICHITA
KARLIN, CHARLES A, SHAWNEE MISSION
KARLIN, RONALD J, OLATHE
KASHA, ROBERT L, WICHITA
KASHYAP, BANSHI PRASAD, SHAWNEE MISSION
KASSEBAUM, GLEN E, EL DORADO
KASSEBAUM, KENNETH G, WICHITA
KASSER, CHRIS L, SHAWNEE MISSION
KATZ, FRED S, SHAWNEE MISSION
KATZ, JEROME B, TOPEKA
KAUFMAN, EUGENE E, WICHITA
KAUFMAN, LELAND R, WINFIELD
KAUFMAN, WILLARD E, MOUNDRIDGE
KAUL, ANAND N, WINFIELD
KAVEL, KARL K, TOPEKA
KAVI, NAGESH G, LEAVENWORTH
KEARNS, NORBERT W, TOPEKA
KEELER, LINDA L, LAWRENCE
KEENE, GEORGE H, WICHITA
KEITH, REX B, SHAWNEE MISSION
KEITH, ROBERT MARSHALL, MAPLE HILL
KELLER, JAMES P, WICHITA
KELLERMAN, RICK, PLAINVILLE
KELLEY, GORDON R, SHAWNEE MISSION
KELLEY, MARSHALL O, SHAWNEE MISSION
KELLING, COLLYER, EMPORIA
KELLY, A CHRISTINE, HAYS
KELLY, DAN A, TOPEKA
KELLY, JIM, SHAWNEE MISSION
KELLY, MICHELE, SHAWNEE MISSION
KELLY, ROBERT W, WICHITA
KENDALL, CALIN T, KANSAS CITY
KENDALL, TOM E, WICHITA
KENDRICK, J GILLERAN, WICHITA
KENNALLY, KEVIN P, SABETHA
KENNEDY, CHRISTOPHER S, KANSAS CITY,MO
KENNEDY, GERALD T, WICHITA
KENNEDY, JAMES A, KANSAS CITY
KENNEDY, KENNETH R, SHAWNEE MISSION
KEPES, JOHN J, KANSAS CITY
KEPKA, DENNIS J, HUTCHINSON
KERBY, GERALD R, KANSAS CITY
KERR, GERALD F, FORT SCOTT
KESTENBAUM, THELDA M, KANSAS CITY
KETCHERSIDE JR, WILLIAM J, KANSAS CITY
KETCHUM, LYNN D, SHAWNEE MISSION
KETTER, IVAN C, SABETHA
*KEYES, MICHAEL J, WICHITA
KEYS JR, ROBERT C, TOPEKA
KEYS SR, ROBERT C, TOPEKA
KHICHA, GYANCHAND J, WICHITA
KHOURY, GEORGE H, WICHITA
KHURANA, SATISH K, SHAWNEE MISSION
KIFER, C JAMES, HAYS
KIHM, ALBERT A, CHANUTE
KIM, JONG M, KANSAS CITY
KIM, PAIK N, WICHITA
KIM, SUCHA, JUNCTION CITY
KIM, YONG W, TOPEKA
KIMBALL, RICHARD R, MANKATO
KIMBLE, JAMES A, WICHITA
KIMMEL, KENNETH K, HALSTEAD
KIMURA, CHARLES C, SHAWNEE MISSION
KIMURA, LYLA S, SHAWNEE MISSION
KIMURA, STEPHEN H, SHAWNEE MISSION
KINDLING, PAUL H, TOPEKA
KINDRED, LYNN H, KANSAS CITY,MO
KING, CHARLES R, KANSAS CITY
KING, TERESA M, KANSAS CITY
KING, WILLIAM T, GREAT BEND
KINNAN, L F, CALDWELL
KINPORTS JR, EDWARD B, KANSAS CITY,MO
KINPORTS SR, EDWARD B, KANSAS CITY,MO
KIRBY, MERLIN G, GREAT BEND
KIRCHNER, FERNANDO R, KANSAS CITY
KIRK, THOMAS E, MANHATTAN
KIRK JR, E DAVID, WICHITA
KIRKEGAARD, RODGER S, TOPEKA
KISER, JOHN L, WICHITA
KISER, WILLARD J, WICHITA
KISHORE, ROY N, PARSONS

* Probationary members.

KISHORE, SHEELA, PARSONS
KITCHEN, ROBERT R, WICHITA
KLAUMANN, MICHELLE A, KANSAS CITY
KLEIN, THOMAS C, KANSAS CITY
KLEINHOLZ JR, EMIL JOHN, TOPEKA
KLEMMER, HERBERT, TOPEKA
KLENDA JR, MARTIN B, BELOIT
KLIEWER, VERNON L, NEWTON
KLINGLER JR, EUGENE A, MANHATTAN
KLINGMAN, DIANE O, WICHITA
KLOBASA, CHARLES L, MANHATTAN
KLOSTERHOFF, BRUCE E, HUTCHINSON
KNAPP, LESLIE E, WICHITA
KNAPP, M ROBERT, WICHITA
KNAPPENBERGER, ROY C, MANITOU SPRING,CO
KNECHT, STEPHEN M, EMPORIA
KNEIDEL, THOMAS W, WICHITA
KNIGHT, LAURA C, WICHITA
KNIGHT, PHILIP J, WICHITA
KNUDSEN, DENNIS L, LIBERAL
KNUTH, KENNETH L, INDEPENDENCE
KODANAZ, A AYTEKIN, SHAWNEE MISSION
KOEHN, DANIEL J, KANSAS CITY
KOKSAL, TOM, GARDEN CITY
KOLSTE, REX J, COLBY
KOONS, JESS W, LIBERAL
KOONTZ, JUDITH A, TOPEKA
KOSAR, CLARENCE O, CONCORDIA
KOURI, SAMMY H, WICHITA
KOVAC, ANTHONY L, KANSAS CITY
KOVARIK, ERNEST D, TOPEKA
KOWALSKI, PETER C, TOPEKA
KOWALSKI, STEPHEN F, TOPEKA
KOZIKOWSKI, BEN M, SHAWNEE MISSION
KRANTZ, KERMIT E, KANSAS CITY
KRATZ, DONALD P, KANSAS CITY
KRAUSE, ROLAND L, WICHITA
KREADY, JOHN L, WICHITA
KREMBIEL, MARK A, SALINA
KRETSINGER OD, W BROCK, EMPORIA
KRISHNAN, LEELA, SHAWNEE MISSION
KROLL, HARRY G, TOPEKA
KRUCKEMYER, ALAN L, SALINA
KRUEGER, HAVEN C, GREAT BEND
KRUEGER, KURT ALLEN, SHAWNEE MISSION
KRUPKA, JOHN J, WICHITA
KUBIN, DORIS A, SHAWNEE MISSION
KUBIN, SUSAN O, WICHITA
KUBINA, GLENN RICHARD, WICHITA
KUEBLER, KEVIN M, KANSAS CITY
KUEKER, RICHARD J, CONCORDIA
KUMAR, SURINDER, NEWTON
KUMMER, ANTHONY J, KANSAS CITY
KURTH, C JOSEPH, WICHITA
KURTH, PAUL H, SHAWNEE MISSION
KURTH, ROBERT H, SHAWNEE MISSION
KUTILEK, FRANK J, WICHITA
KYI, WIN M, DODGE CITY
KYNER, JOSEPH L, KANSAS CITY

L

LABHSETWAR, S A, JUNCTION CITY
LACCHEO, MICHAEL L, TOPEKA
LAFENE, BENJAMIN W, MANHATTAN
LAHAM, ALEXANDER J, DALLAS,TX
LAI, CHI-WAN, KANSAS CITY
LAI, JENG Y, WICHITA
LAI, MAX G, TOPEKA
LAI-CHEN, SHEUE-HUEY, TOPEKA
LAING, ROBERT R, KANSAS CITY
LAIRD, DALE O, OLATHE
LAKE, MAX S, SALINA
LANCE, RAYMOND W, PITTSBURG
LANCE JR, JOHN F, WICHITA
LAPI, RUTH M, SHAWNEE MISSION
LARSON, DANUTA OKTAWIEC, SHAWNEE MISSION
LARSON, DELBERT L, HIAWATHA
LASH, RAY E, SHAWNEE MISSION
LASLEY, DAVID A, SALINA
LASLEY, MICHAEL B, HAYS
LATIMER, KATHERINE, WICHITA
LAUDERT, SUSAN E, WICHITA
LAUNEY, WALTON S, TOPEKA
LAURY, DAVID G, OTTAWA
LAUVER, MARY ANN, WICHITA
LAVA, CHIRUND, PARSONS
LAW, FINDLEY, ELLINWOOD
LAWHEAD, JEFF O, KANSAS CITY
LAWHORN, CHARLTON O, KANSAS CITY
LAWHORN, STEPHANIE LU, KANSAS CITY
LAWLESS, HAROLD L, BLUE RAPIDS
LAWN, CLAUDIA A, WICHITA
LAWN, RAYMOND A, WICHITA
LAWRENCE, GILBERT A, SALINA
LAWS, LEWIS R, MARYSVILLE
LAWSON, DWIGHT, TOPEKA
LAWTON, MARVIN K, CONCORDIA
LAWTON, STEVEN K, SHAWNEE MISSION
LAWWILL, THEODORE, KANSAS CITY
LAYBOURNE JR, PAUL C, KANSAS CITY
LE, CHUONG DUC, GARDEN CITY
LEAHY, JAMES D, SHAWNEE MISSION
LEAR, REX V, WICHITA
LEARNED, GEORGE R, LAWRENCE
LEATHERS, MOLLIS K PAT, SHAWNEE MISSION
LEAVELL, MICHAEL E, BALDWIN,MO

LEE, JAE M, KANSAS CITY
LEE, KYO R, KANSAS CITY
LEE, R REX, WICHITA
LEE, SONG DOW, TOPEKA
LEE, SONG PING, TOPEKA
LEE, YONG U, EL DORADO
LEE JR, EDWARD S, WICHITA
LEE JR, JAMES G, SHAWNEE MISSION
LEFFLER, PAUL B, PITTSBURG
LEGASPI JR, PEDRO L, SHAWNEE MISSION
LEGER, LEE H, FT MYERS,FL
LEHMAN, KARL D, KANSAS CITY
LEIFER, WILLIAM N, TOPEKA
LEIKER, JOSEPH, ARKANSAS CITY
LEISY, JERALD W, WICHITA
LEITCH, DAVID A, GARNETT
LEITNER, YORAM B, WICHITA
LEMOINE JR, ALBERT N, KANSAS CITY
LENEVE, ROBERT T, PERKINS,OK
LENSKI JR, FRANCIS X, IDLA
LENTZ, WILLIAM R, TOPEKA
LEO, WILLIAM A, KANSAS CITY
LESSENDEN, GLENN A, LAWRENCE
LESSENDEN JR, C M, TOPEKA
LESSER, DANE A, HUTCHINSON
LESSIN, DIANNA L, KANSAS CITY,MO
LESTER, JOHN BUCKLES, SHAWNEE MISSION
LETTNER, HANS T, HUTCHINSON
LEUGER D.O., JAMES JOHN, SENECA
LEVINE, ERROL, KANSAS CITY
LEVINE, WILLIAM R, WICHITA
LEVY, EDWIN Z, TOPEKA
LEWIN, WALTER, SHAWNEE MISSION
LEWIS, JAMES E, SHAWNEE MISSION
LEWIS JR, H DANIEL, KANSAS CITY,MO
LHEVINE, DAVE B, TULSA,OK
LIBEL, ROY, KANSAS CITY
LICHTENHAN, JOHN B, KANSAS CITY
LIEBERMAN, BRUCE IRWIN, KANSAS CITY
LIES, BARTHEL N, COLWICH
LIES, RICHARD B, WICHITA
LIESMANN, GEORGE E, TOPEKA
LIESMANN, JEAN ELIZABETH, TOPEKA
LILLICH, MAUREEN A, KANSAS CITY,MO
LIN, JOE J, WICHITA
LINO II, EDWARD J, GARDEN PLAIN
LINDHOLM, GERALD R, NEWTON
LINDSLEY, CAROL B, KANSAS CITY
LINDSLEY, HERBERT B, KANSAS CITY
LINDSTROM, LORI A, WICHITA
LINHAROT, RONALD O, WICHITA
LINN, CATHERINE P, KANSAS CITY
LIPOFF, JAY I, LEAVENWORTH
LIPSEY, JAMES H, SHAWNEE MISSION
LITTELL, JAMES A, WICHITA
LITTLE, L GILBERT, WICHITA
LIU, ALBERT T, KANSAS CITY
LIU, CHIEN, KANSAS CITY
LIVINGSTON, CHARLES E, SALINA
LLOYD, HARVEY L, KANSAS CITY
LLOYD, JAMES W, CONCORDIA
LOCKHART, JOSEPH G, WICHITA
LOEB, ELBIE L, HAYS
LOEFFLER, JAMES A, WICHITA
LOEWEN, HENRY H, WICHITA
LOEWEN, WILLIAM C, WICHITA
LOGAN, GEOFFREY G, WICHITA
LOGANBILL, VAROEN J, MOUNDRIDGE
LOHMEYER, KENNETH L, GREEN VALLEY,AZ
LOKER, JAMES L, SHAWNEE MISSION
LONEY, JOHN M, BELOIT
LONG, EDWARD E, HUMBOLDT
LONG, LLOYD O, GOODLAND
LONG, ROBERT C, NORTON
LORTZ, PHILIP W, KANSAS CITY
LOSEE, JOHN M, WICHITA
LOVE, ROBERT H, WICHITA
LOVELAND, G CHARLES, LAWRENCE
LOVETT, BRENT R, KANSAS CITY,MO
LOVETT, PAUL A, WICHITA
LOW, HAROLD L, WICHITA
LOWE, STANLEY W, MANHATTAN
LUALLIN, SCOTT R, SHAWNEE MISSION
LUBETICH JR, JOHN F, KANSAS CITY
*LUCAS, GEORGE L, WICHITA
LUCKEROTH, LEAH L, KANSAS CITY,MO
LUEKEN, LUEKE B, WICHITA
LUELLEN, THOMAS J, WICHITA
LUETJE, CHARLES MARION, KANSAS CITY,MO
LUI, NASON, TOPEKA
LUKENS, DAVID, HUTCHINSON
LUKERT, BARBARA P, KANSAS CITY
LULO, ANTONIO R, SHAWNEE MISSION
LUMB, RAYMOND C, TOPEKA
LUNBERRY-HILL, JULIA, WICHITA
LUNGSTRUM, JACK E, SALINA
LUZZATI, ENZO F, WICHITA
LYGRISSE, DANIEL V, WICHITA
LYLE, LINDA S, WICHITA
LYNCH, JOHN A, TOPEKA
LYNCH, MARY A, WICHITA
LYNCH, SEAN R, KANSAS CITY
LYONS JR, FRANK C, MANHATTAN

M

MABEN, PAMELA S, CHANUTE
MAC KILLOP JR, DANIEL, WINFIELD

*MACARTHUR, RICHARD IAN, TOPEKA
MACDOUGALL, MARGARET L, SHAWNEE MISSION
MACE, RONALD D, JUNCTION CITY
MACY, NORMAN E, SALINA
MACY, TED L, SALINA
MADDEN, CATHERINE E, WICHITA
MADER, ELAINE M, WICHITA
MADISON, JAMES G, SHAWNEE MISSION
MADISON, RANDALL W, SHAWNEE MISSION
MADISON, WILLARD A, NORTONVILLE
MADISON JR, WARD N, WICHITA
MADSEN, GLENN L, LAWRENCE
MAGEE, LAWRENCE M, LAWRENCE
MAGEE, SHAWN M, SHAWNEE MISSION
MAGIOSON, ELLIOTT ARTHUR, WICHITA
*MAGSALIN, ROMULO O, WICHITA
MAILMAN, GERSHOM, WICHITA
MALLORY, JOHN A, SHAWNEE MISSION
MALONE, DAVID G, KANSAS CITY
MALONE, EUGENE M, HALSTEAD
MANAHAN, G EUGENE, LAWRENCE
MANDELBAUM, MARK A, WICHITA
MANGOLD, JOEL VOYCE, KANSAS CITY
MANI, MANI M, KANSAS CITY
MANLEY, JOSEPH W, SHAWNEE MISSION
MANNING, ROBERT T, WICHITA
MANSOUR, BADIE S, WICHITA
MANTZ, FRANK A, SHAWNEE MISSION
MARCHBANKS, DONALD L, SALINA
MARGOLIS, MICHAEL T, KANSAS CITY
MARPLES, BRADLEY W, KANSAS CITY
MARSH, ALICE GARRISON, KANSAS CITY
MARSH, CONNIE M, HALSTEAD
MARSH, HENRY O, WICHITA
MARSHALL, B M, TOPEKA
MARSHALL, GEORGE W, SALINA
MARSHALL, ROGER W, EL DORADO
MARSHALL, RONALD L, MANHATTAN
MARTIN, CLYDE V, VACAVILLE,CA
MARTIN, DANIEL C, MANHATTAN
MARTIN, EARL A, PARSONS
MARTIN, JOSEPH P, KANSAS CITY
MARTIN, NORMAN L, KANSAS CITY
MARTIN, OLIVER L, SALINA
MARTIN, RONALD L, KANSAS CITY
MARTIN, WILLIAM O, TOPEKA
MARTIN JR, GLEN E, WICHITA
MARTINAK, JOSEPH F, TOPEKA
MARTINEZ, JOHN O, HUTCHINSON
MARVEL, JAMES EBBERT, ARKANSAS CITY
MARVIN, NORMAN G, SHAWNEE MISSION
MARYMONT JR, JESSE H, WICHITA
MASER, GEORGE R, SHAWNEE MISSION
MASON, ROGER, PRATT
MASSOTH, SUE V, WICHITA
MASTERS, FRANCIS W, KANSAS CITY
MASTERSON, MELVIN LEROY, TROY
MASTIO JR, GEORGE J, WICHITA
MATASSARIN, BENJAMIN M, WICHITA
MATASSARIN, FREDERICK W, WICHITA
MATHEWS, DAVID R, SHAWNEE MISSION
MATHEWS, ROBERT C, OLATHE
MATHEWS, ROBERT MAJOR, SHAWNEE MISSION
MATHEWSON, HUGH S, KANSAS CITY
MATTHEW, WILLIAM L, OLATHE
MATTHEWS, EARL H, SALINA
MATTHEWS, GEORGE E, O.D., GARDEN CITY
MATTICK, IRVIN H, HAYS
MATTIOLI, LEONE, KANSAS CITY
MATZEN, TED A, SHAWNEE MISSION
MAU, WALTER, TOPEKA
MAUCK, HAROLD C, STOCKTON
MAWDSLEY, MICHAEL W, WICHITA
MAXFIELD, RUSSELL J, COLORADO SPRING,CO
MAXWELL, GORDON E, SALINA
MAXWELL, ROBERT A, SHAWNEE MISSION
MAY, KENNETH L, BONNER SPRINGS
MC ALLISTER, SCOTT H, KANSAS CITY
MC BATH, TIM L, WICHITA
MC CROSKEY, BRIAN L, SHAWNEE MISSION
MC FARLAND, GRETA S, CIMARRON
MC FARLANE, MICHAEL J, KANSAS CITY
MC PHEE, MARK S, KANSAS CITY
MCALLASTER, WENDALE E, GREAT BEND
MCBOYLE, MARILEE, WICHITA
MCCANN, PATRICK E, FORT SCOTT
MCCANN, WILLIAM E, OLATHE
MCCARTER, DUANE K, TOPEKA
MCCARTHY, ROBERT P, KANSAS CITY
MCCAUGHEY, HUGH W, SHAWNEE MISSION
MCCLANAHAN, WARD A, WICHITA
MCCLEAY, PETER O, KANSAS CITY,MO
MCCLELLAN, ERNEST L, WICHITA
MCCLELLAN, JOHN W, TOPEKA
MCCLURE, JAMES A, TOPEKA
MCCOLLUM, WILLIAM B, LEAVENWORTH
MCCOMAS JR, MARMADUKE O, TOPEKA
MCCOWEN, HERBERT M, SHAWNEE MISSION
MCCOY, C PATRICK, WICHITA
MCCOY, CHARLES P, WICHITA
MCCOY, CHARLES T, HUTCHINSON
MCCOY, MICHAEL T, TOPEKA
MCCOY, RONALD, DODGE CITY
MCCRAE, SPENCER C, SALINA
MCCULLOUGH, JAMES P, WICHITA
MCCULLOUGH, ROBERT C, GOODLAND
MCCUNE, MARK A, KANSAS CITY
MCDONALD, KEVIN R, HAYS
MCDONALD, THOMAS L, SHAWNEE MISSION
MCDONOUGH, W DAVID, WICHITA
MCEACHEN, WILLIAM H, SHAWNEE MISSION

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MCGURK, THOMAS E, KANSAS CITY,MD
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MCKENNA, MICHAEL J, FORT SCOTT
MCKERRACHER, RDBERT O, DERBY
MCKINNEY, SHARON L, O.O., TDPEKA
MCKITTRICK, RICHARD, KANSAS CITY
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MCKNIGHT, ELLIS B, ALMA
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MCMULLEN, BRUCE R, WICHITA
MCMULLEN, JOSEPH E, HUTCHINSON
MCNEIL, ELBERT O, MANHATTAN
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MCQUEEN, DAVID ARNOLD, WICHITA
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MEANS, MILA LEE, WICHITA
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MECH, ARNDLD W, TDPEKA
MEDHAT, MDHAMED A, KANSAS CITY
MEE, ADRIAN W, OLATHE
MEEK, PALMER F, MANHATTAN
MEEK JR, JOSEPH C, WICHITA
MEEKER II, BRUCE P, WICHITA
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MEIDINGER, RICHARD, TOPEKA
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MELENDRES, JUANITO M, OLATHE
MELHORN, J MARK, WICHITA
MELHORN, KATHERINE J, WICHITA
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MENAKER, JERDME S, WICHITA
MENDIONES, L MARLENE, WICHITA
MENDIONES, RUPERTO O, WICHITA
MENDLICK, R MICHAEL, OLATHE
MENEHAN, H JAMES, WICHITA
MENEZ, CESAR V, SHAWNEE MISSION
MENHUSEN, MONTY J, O.O., WICHITA
MENKING, F W MANFRED, WICHITA
MENKING, SUSAN MARGARET, WICHITA
MENNINGER, KARL A, TOPEKA
MENNINGER, RDBERT G, TOPEKA
MENNINGER, RDY W, TOPEKA
MENNINGER, W WALTER, TOPEKA
MENZIE, LISA O, KANSAS CITY
MERCADER, MARID S, WICHITA
MEREDITH, W TDM, WICHITA
MERIFIELD, CHRISTOPHER D, SHAWNEE MISSION
MERKEL, EARL O, RUSSELL
MERRIFIELD, TERRY S, WICHITA
MERRITT, JDE P, OKLAHOMA CITY,DK
MERRITT, W HENRY, LEAVENWORTH
MERSHON, JAMES C, WICHITA
MESINA, RDLANDO R, KANSAS CITY
MESSAMORE, DEBRA L, WICHITA
MEYER, JACK R, NORTON
MEYER, MARK E, TDPEKA
MEYER, O WARREN, TOPEKA
MEYER, WARREN E, WICHITA
MEYERS, JOHN J, KANSAS CITY
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MHATRE, VIJAY R, TOPEKA
MICHELBACH, ALBERT P, WICHITA
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MIH, ALEXANDER, CHANUTE
MILFELD, DDUGLAS J, WICHITA
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MILLER, DAVID PATERSON, WICHITA
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MILLER, DENNIS W, KANSAS CITY
MILLER, DON E, WICHITA
MILLER, EARL E, PITTSBURG
MILLER, ELDEN V, SALINA
MILLER, FRANKLIN R, WINFIELD
MILLER, FREEMAN LANCE, SHAWNEE MISSION
MILLER, HERBERT C, NORFORD,CT
MILLER, KEVIN B, KANSAS CITY
MILLER, KEVIN E, KANSAS CITY
MILLER, LAWRENCE H, WAUPUN, WI
MILLER, MONTE B, SAN ANTONIO,TX
MILLER, PHILIP A, PHOENIX,AZ
MILLER, ROBERT E, GARDEN CITY
MILLER, ROGER M, WICHITA
MILLER, STEPHEN FRANCIS, PARSONS
MILLER, TODD A, ATCHISON
MILLIGAN, DONALD B, KANSAS CITY
MILLS, CHARLES O, WICHITA
MILLS, KIRK C, WICHITA
MILLS, MELISSA J, KANSAS CITY,MD
MILLS, PHILIP R, WICHITA
MILLS, VERNON A, LEAVENWORTH
MILLS JR, PHILIP E, TOPEKA
MINER JR, PHILIP B, KANSAS CITY
MINNICK, CHARLES V, JUNCTION CITY
MINNS, GAROLD O, WICHITA
MIRZA, MEOD, WICHITA
MISKEW, DON B W, SHAWNEE MISSION

MITCHELL, ALEX C, LAWRENCE
MITCHELL, DEANNA SUE, KANSAS CITY
MITCHELL, ROBERT H, GARDEN CITY
MITRA, SUDHEER, GOODLAND
MITTS, ERNEST W, BONNER SPRINGS
MODDRELL, CAROL A, LAWRENCE
MOOLIN, HERBERT C, TOPEKA
MOELLER, DONALD O, KANSAS CITY
MOFFAT, ROBERT E, SHAWNEE MISSION
MOHLER, JACK M, ABILENE
MONCKTON, LAURANCE A, LAWRENCE
MONTGOMERY, THOMAS ALLEN, SABETHA
MONTGOMERYSHORT, RUTH G, WICHITA
MOORE, DENNIS F, WICHITA
MOORE, HUGH C, TOPEKA
MOORE, JAMES E, CONCORDIA
MOORE, ROBERT, HOISINGTON
MOORE, ROBERT F, CANEY
MOORE, THOMAS A, WICHITA
MOORE, WAYNE V, KANSAS CITY
MORHEAD JR, F ALLEN, NEDDESHA
MORFFI, RAUL R, KANSAS CITY
MORGAN, JAMES I, WICHITA
MORGAN, JOHN L, EMPORIA
MORGAN, NOVA L, HAYSVILLE
MORGAN, RANDALL J, WICHITA
MORGAN II, DAVID LLOYD, OLATHE
MORGAN III, LOUIS S, WICHITA
MORITZ, RICK S, SHAWNEE MISSION
MORONEY, JEAN M, SHAWNEE MISSION
MORRIS, MERLE D, TOPEKA
MORRISON, IRA R, ATCHISON
MORRISON, MICHAEL R, TOPEKA
MORRISON, RICHARD L, WICHITA
MORROW, THOMAS F, WICHITA
MORROW JR, J TARLTON, TOPEKA
MORTON, JOHN E, GARDEN CITY
MORTON, ROBERT A, ARKANSAS CITY
MOSELEY, JACK E, WICHITA
MOSER, ERNEST C, HOLTON
MOSIER, MICHAEL L, MANHATTAN
MOSIER, STANLEY JAY, WICHITA
MOSIER, STEVEN J, MANHATTAN
MOWERY, WILLIAM E, SALINA
MOWRY, GERALD L, MANHATTAN
MOYER, HERMAN J, DERBY
MUEHLBERGER, JAMES J, SHAWNEE MISSION
MUELLER, ARNOLD V, TOPEKA
MUELLER, J KENT, SHAWNEE MISSION
MUELLER, MICHAEL A, KANSAS CITY
MUELLER, VERNETTE A, WICHITA
MUETH, JOAN O, WICHITA
MUKERJEE, SANDEEP, KANSAS CITY,MD
MULL, JOHN C, HUTCHINSON
MULLEN SR, CLIFFORD J, KANSAS CITY
MULLER, SAMUEL B, PITTSBURG
MULLINIX, JANICE M, WICHITA
MUNDEN, FRANK A, SHAWNEE MISSION
MURFITT, MALCOLM C, LINDSBORG
MURPHY, BARRY L, WICHITA
MURPHY, DUANE A, WICHITA
MURPHY, JAY W, SHAWNEE MISSION
*MURPHY, PATRICK L, WICHITA
MURPHY, PAUL M, WICHITA
MURPHY, TIMOTHY P, KANSAS CITY
MURPHY, WILLIAM R, KANSAS CITY
MURPHY, WILLIAM R C, WICHITA
MURRAY, KENT B, WICHITA
MURRAY, W LEE, SHAWNEE MISSION
MYERS, JO ANN, TOPEKA
MYERS, W EUGENE, IOLA
MYERS JR, EARL B, INDEPENDENCE
MYRICK, MICKEY, HAYS
MYRICK, STEPHEN W, LAWRENCE

N

NABORS, RICHARD O, TOPEKA
NACHTIGALL, ANDREW, NEWTON
NADER, DADKAH, KANSAS CITY
NALOOZA JR, FAUSTINO M, WELLINGTON
NANCE, JOEL, TOPEKA
NARCISO, VICENTE D, ABILENE
NASH, NEWMAN CURTIS, SCOTTSDALE,AZ
NASH, ROBERT A, SHAWNEE MISSION
NATHAN, WILLIAM A, TOPEKA
NAUER, PAULA LOU, SHAWNEE MISSION
NAVICKAS, LEONARD A, SHAWNEE MISSION
NAZARIO, LILIANA E, SHAWNEE MISSION
NEASE JR, DONALD E, WICHITA
NEEL, WILBUR B, HUTCHINSON
NEFF, JAMES R, KANSAS CITY
NEIBURGER, JAMES B, SHAWNEE MISSION
NEIGHBOR, ERNEST G, KANSAS CITY
NEIGHBOR, ERNEST H, KANSAS CITY
NEIGHBOR, GAYLORD P, KANSAS CITY
NEIGHBOR, RALPH M, EMPORIA
NEIL, ROY NEWTON, HAYS
NEIS, HARRY B, OSAGE BEACH,MO
NELLIS, STEPHANIE F, WICHITA
NELSON, BRENDA S, KANSAS CITY
NELSON, BRYAN C, SHAWNEE MISSION
NELSON, CHARLES G, SHAWNEE MISSION
NELSON, GERALD O, WICHITA
NELSON, JOHN B, SHAWNEE MISSION
NELSON, NANCY A, KANSAS CITY
NELSON, PAUL L, CONCORDIA
NELSON, RICHARD O, LAWRENCE
NELSON, RUSSELL ALAN, WICHITA
NELSON, T EUGENE, FORT SCOTT
NELSON JR, GUST H, WICHITA
NEMMERS, DAVID J, WINFIELD
NESMITH, LESLIE W, WICHITA
*NETHERTON, DAVID M, WICHITA
NEUENSCHWANDER, JOHN, HOXIE
NEUENSCHWANDER, JOHN RAND, HOXIE
NEUER, FREDERICK S, EMPORIA
NEUFELD, BRENDA G, KANSAS CITY,MD
NEUMANN, JAMES W, SALINA
NEUSCHAFER, DARREL R, HUTCHINSON
NEVINS, RICHARD L, LIBERAL
NEWBY, JAMES P, WICHITA
NEWCOMB, WARD M, HAYS
NEWLIN, PHILIP L, WICHITA
NEWMAN, CARL T, CONCORDIA
NEWMAN, CLIFFORD B, PITTSBURG
NEWSOM, F CARTER, WICHITA
NEWTON, CHARLES R, VISALIA,CA
NIBBELINK, LARRY WAYNE, KANSAS CITY
NICE, G WILLIAM, TOPEKA
NICHOLS, ROBERT R, FORT SCOTT
NICKELL, WENDELL K, SALINA
NIEDEREE, DAVID W, DERBY
NIEDEREE, W CURTIS, GREAT BEND
*NIELSEN, MARY L, WICHITA
NIEMAN, JOHN L, SHAWNEE MISSION
NIENSTEDT, JOHN F, SUN CITY,AZ
NIGHTENGALE, DIANE J, NEWTON
NIKNIA, SEYED M, GARDNER
NIXON, DAVID W, KANSAS CITY
NIXON, JAMES E, DODGE CITY
NIXON, RICHARD R, SALINA
NIXON, WILLIAM A, WICHITA
NOBLE, MARK J, KANSAS CITY
NORMAN, BENJAMIN R, WICHITA
NORRIS, CHARLEY W, KANSAS CITY
NORRIS, ROBERT P, WICHITA
NORTH, DORIS G, WICHITA
NORTON, ROBERT K, WICHITA
NOSTI, JUAN C, SHAWNEE MISSION
NOTHNAGEL, ARNOLD F, KANSAS CITY
NOTTINGHAM, ROBERT M, OLATHE
NOVOTNY, PETER C, TOPEKA
NOWLIN, NANCY S, WICHITA
NULA, RICHARD F, WICHITA
NULL, WILLIAM G, SALINA
NUNEMAKER, MARION E, HUTCHINSON
NUNEZ, JULIAN, SHAWNEE MISSION
NYBERG, FREDRIK F, TONANDA
NYE, C ERIK, SHAWNEE MISSION

D

O'BOYNICK II, PAUL LEONARD, KANSAS CITY
O'BRYAN, JAMES J, SHAWNEE MISSION
O'DELL, MICHAEL L, KANSAS CITY
O'DONNELL, HAROLD F, ELLSWORTH
O'DONNELL, HARRY E, JUNCTION CITY
O'DONNELL, JANAT E, KANSAS CITY
O'DONNELL, RICHARD H, CLAY CENTER
O'DONNELL JR, LEONARD A, WICHITA
O'NEIL, ROBERT H, TOPEKA
OBANDO, GUILLERMO, SALINA
OBOURN, ROBERT L, TOPEKA
OCHSNER, BRUCE B, WICHITA
ODENHEIMER, BURTRAM J, WICHITA
ODGERS, ROONEY K, PITTSBURG
OELSCHLAGER, RONALD O, LAWRENCE
OHMAN, RICHARD J, DODGE CITY
OHMART, RICHARD V, OAKLEY
OLD, JERRY L, ARKANSAS CITY
OLMSTEAD, CALVIN G, HUTCHINSON
OLNEY, ROBERT D, MANHATTAN
OLSEN, PHILLIP S, EL DORADO
OLSON, CARL E, LAWRENCE
OLSON, CLITUS W, GODDLAND
OLSON, ERWIN T, NEWTON
OLSON, THOMAS H, SHAWNEE MISSION
OMOAHL, NICHOLAS S, HUTCHINSON
ONG, CATHERINE M, SHAWNEE MISSION
OPENSHAW, CALVIN R, HUTCHINSON
ORCHARD, RICHARD A, LAWRENCE
ORR, STEVEN M, KANSAS CITY,MD
ORTH-BAALMAN, DIANE M, WICHITA
OSBERN, LIDA, LAWRENCE
OSBORN, J CLARK, WICHITA
OSBORNE, CONRAD C, WICHITA
OSGOOD, GEORGE M, SHAWNEE MISSION
OSIO, ANTONIO L, WICHITA
OSOBA, WILLIAM G, WICHITA
OSOFSKY, HOWARD J, TOPEKA
*OSTER, JOYCE A, WICHITA
OTHMER, EKKEHARD, KANSAS CITY
OUANO JR, BIBIANO B, WICHITA
OVERFIELD, A SCOTT, KANSAS CITY
OVERHOLSER, NORMAN H, EL DORADO
OWEN, LARUE W, WICHITA
OWEN, PERE A, WICHITA
OWEN III, JAMES W, TOPEKA
OWENS, RICHARD L, KANSAS CITY
OWENSBY, L C, CONCORDIA
OXLER JR, JOHN EDWARD, KANSAS CITY
OYER, FREDERICK R, HUTCHINSON
OYLER, JONATHAN M, OLATHE

* Probationary members.

P

PACE, JOHN O, PARSONS
PAGE, O VALE, PLAINVILLE
PAGE, RUTH, WICHITA
PAI, RADHA V, PARSONS
PAI, VARADARAJ S, PARSONS
PAIGE, ANGELA A, KANSAS CITY
PAINE, GEORGE E, HUTCHINSON
PALMBERG, KENT E, TOPEKA
PALMER, DAVID L, WICHITA
PALMER, GERALD K, SALINA
PALMER, MARGUERITE L, OBERLIN
PALMER, MARVIN M, KANSAS CITY
PANICHABHONGSE, SAMBHUNDH, RUSSELL
PAPP JR, S DEAN, PITTSBURG
PARANJOTHI, SUBRAMONIAM P, PARSONS
PAROD, LILLIAN G, KANSAS CITY
PAROD, MANUEL P, KANSAS CITY
PAREKH, AJITKUMAR M, KANSAS CITY
PARHAM, VERDON W, CHANUTE
PARK, CHAN H, KANSAS CITY
PARK, ROGER WALTER, WICHITA
PARKER, HAROLD L, WICHITA
PARKER, JULIE A J, KANSAS CITY
PARKER, ROBERT W, LEAVENWORTH
PARKER, WAYNE G, MADISON
PARKS, DOUGLAS S, SALINA
PARMAN, CRAIG R, WICHITA
PARMAN, ROBERT D, TOPEKA
PARRA, DANIEL C, KANSAS CITY
PARRA, MIGUEL O, KANSAS CITY
PARSI, MANUTCHEHR K, PITTSBURG
PARSONS, JULIE A, WICHITA
PARULKAR, DEEPAK S, TOPEKA
PASCUA, PERCIVAL G, TOPEKA
PASIMIO, ROGER S, COLUMBUS
PASSMAN, STEVEN M, WICHITA
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PATEL, MAHENDRA N, JUNCTION CITY
PATEL, V C, INDEPENDENCE
PATEL, VINOD, TOPEKA
PATRICK, FRED EDWARD, TOPEKA
PATRON, RICARDO A, EL DORADO
PATRON, RICARDO F, KANSAS CITY
PATTERSON, JOHN R, SHAWNEE MISSION
PATTON, J MICHAEL, WICHITA
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PAULS, DAVID G, KANSAS CITY
PAVELONIS, JOEL D, SHAWNEE MISSION
PAXTON, EDWARD SCOTT, WICHITA
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PAYNE, J RALPH, KANSAS CITY, MO
PAYNE, ROBERT R, TOPEKA
PAZELL, JOHN A, KANSAS CITY
PEARCE, EUGENE W J, SHAWNEE MISSION
PEARCE, LUNETTA M, SHAWNEE MISSION
PEARSON, MARK A, SHAWNEE MISSION
PEASE, GARY L, HUTCHINSON
PECK, ROGER, GREAT BEND
PEDERSON, ARNOLD M, PLAINVILLE
PEDRAZA, HERNANDO, WELLINGTON
PEERY, WILLIAM H, WICHITA
PEES, GERALD B, APOLLO BEACH,FL
PEES JR, GERALD BOYD, LAWRENCE
PEFFLY, ELMER D, CHETOPA
*PEIL, MICHAEL L, WICHITA
PELLETIER JR, LAWRENCE L, WICHITA
PENCE, CHARLES O, WICHITA
PENN, CHRISTOPHER C, WICHITA
PENN, GEORGE M, TOPEKA
PENNER, TIMOTHY M, KANSAS CITY
PENNINGTON, KATHERINE, WICHITA
PENTECOST, RICHARD L, SHAWNEE MISSION
PEROUE II, W LANG, TOPEKA
PEREIRA, WILLY G, ARKANSAS CITY
PERICO, CARLOS J, SHAWNEE MISSION
PERIDO, DOMINADOR T, ELKHART
PERKINS, JACK L, HUTCHINSON
PERRY JR, LAWRENCE L, KANSAS CITY
PERSONS, DIANE L, KANSAS CITY,MO
PETELIN, JOSEPH B, SHAWNEE MISSION
PETERIE, JERRY P, WICHITA
PETERS, ERIC A, KANSAS CITY
PETERS, THOMAS J, WICHITA
PETERSEN, A GENE, SHAWNEE MISSION
PETERSEN, GERALD D, SHAWNEE MISSION
PETERSEN, MARK I, SHAWNEE MISSION
PETERSON, DEAN L, TOPEKA
PETERSON, JACK T, MANHATTAN
PETERSON, JAMES E, SALINA
PETERSON, ROBERT L, TOPEKA
PETERSON, VERNON J, TOPEKA
PETERSON JR, EVAN A, WATHENA
PETIT, CARL, SHAWNEE MISSION
PETRIE, SAMUEL C, SHAWNEE MISSION
PETRIK, EDWIN L, TOPEKA
PETTERSON, CECIL E, SYRACUSE
PETTERSON, DENNIS CRAIG, TOPEKA
PETTERSON, DORUTH S, RIDGEVILLE,IN
PETTIJOHN, WALTER J, RUSSELL
PFUETZE, BRUCE L, SHAWNEE MISSION
PFUETZE, KARL O, SHAWNEE MISSION
PFUETZE, ROBERT E, TOPEKA
PHAN, DUNG MY, WICHITA
PHELPS, DAVID WAYNE, FORT SCOTT
PHILGREEN, DONALD E, OTTAWA
PHILIPP, JOSEPH THEODORE, MANHATTAN
PHILLIPS, WARREN G, SHAWNEE MISSION
PHIPPS, JACK G, WICHITA
PHIPPS, RONNY G, INDEPENDENCE
PIBURN, MARVIN F, WICHITA
PICKENS, ANDREW T, WICHITA
PIERCE, CHARLES F, TOPEKA
PIERCE, DONALD R, TOPEKA
PIERCE, GEORGE E, KANSAS CITY
PIERRON, GEORGE J, OLATHE
PIERSON, MARK E, EMPORIA
PIERSON, WEIR, MCPHERSON
PILCHARD, WILLIAM A, SHAWNEE MISSION
PINGLETON, SUSAN K, KANSAS CITY
PINGLETON, WILLIAM WARREN, SHAWNEE MISSION
PINKERTON, LYNNE E, KANSAS CITY
PINKHAM, CHRIS M, KANSAS CITY,MO
PINSKER, JACOB A, WICHITA
PIPPIN, LYNNE K, KANSAS CITY
PITTS, RONALD L, SHAWNEE MISSION
PIZARRO, FE E, DODGE CITY
PLACEK, DEBRA C, LAWRENCE
PLOWMAN, CARL W, JEWELL
PODREBARAC, FRANCIS A, KANSAS CITY
POGSON, GEORGE W, PITTSBURG
*POLINER, LAWRENCE R, WICHITA
POLING, TERRY L, WICHITA
POLLACK, SIMON, WICHITA
POLLANO, STEPHEN M, O.D., WICHITA
POLLOCK, ANTHONY G A, WICHITA
POLLY, RICHARD E, TOPEKA
POLSON, ROBERT C, GREAT BEND
POMMERENKE, FORREST A, DE SOTO
POOLE, BERNARD T, WICHITA
POOLE, EDWARD C, KANSAS CITY
PORTER, DAVID M, KANSAS CITY
PORTER, GARRY L, WICHITA
PORTER, ROBERT D, TOPEKA
PORTER, SUSAN S, KANSAS CITY
PORTER, TAYLOR L, WICHITA
POSS, WILLIAM B, SHAWNEE MISSION
POTTER, ROBERT L, KANSAS CITY
POWELL, CAROL W, SHAWNEE MISSION
POWELL, KENNETH A, SHAWNEE MISSION
POWELL, WILLIAM R, TOPEKA
POWELL II, BENSON M, TOPEKA
POWERS, G ROBERT, KANSAS CITY
POWERS, HAROLD W, SUN CITY,AZ
POWERS, K DEAN, WICHITA
PRAEGER, MARK A, LAWRENCE
PRAKALAPAKORN, DARANEE, NESS CITY
PRAKALAPAKORN, YANYONG, NESS CITY
PRAY, CLAUDIA M, LEAVENWORTH
PREMSINGH, NALINI G, KANSAS CITY
PRENDES, CARLOS A, SHAWNEE MISSION
PRENTICE, WALTER B, INDEPENDENCE
PRENTISS, HAROLD, NEWTON
PRESTON, DAVID F, KANSAS CITY
PRESTON, RALPH R, TOPEKA
PRESTON, RICHARD, GREAT BEND
PRETZ, JAMES B, KANSAS CITY
PRICE, HILTON I, KANSAS CITY
PRICE, JAMES GORDON, KANSAS CITY
PRICE, VAUGHAN C, MCPHERSON
*PRICE JR, LAURANCE W, TOPEKA
PRIETO, JORGE N, KANSAS CITY
PROCHASKA, MARK L, TOPEKA
PROCHAZKA, OTTO F, LIBERAL
PROKOP, BRADFORD S, TOPEKA
PRONKO, MICHAEL J, SHAWNEE MISSION
PROUD, G ONEIL, KANSAS CITY
PRUITT, DAVID E, KANSAS CITY,MO
PUCKETT, MICHAEL L, KANSAS CITY
PUGH, DAVID M, KANSAS CITY
PULLMAN, NORMAN K, WICHITA
PULLUM, RICHARD W, O.D., WICHITA
PURINTON, LEW W, WICHITA
PUTNAM, LYLE B, WICHITA
PYLE, LUCIEN R, TOPEKA

Q

QAMAR, YUSUF, NEWTON
QUENZER, RONALD W, PRATT
QUIGLEY, JAMES, SHAWNEE MISSION
QUIJANO JR, RAMON S, STAFFORD
QUINN, CHARLES E, KANSAS CITY
QUINONES, ELADIO A, TAMPA,FL
QURESHI, HUMAYUN, HUTCHINSON

R

RABE, MELVIN A, LEAVENWORTH
RADOM, SANFORD B, FORT SCOTT
RADOVANOV, RADMILA, NEWTON
RAGHAVAN, PARULA P, WICHITA
RAGHAVAN, PRAKASH V, WICHITA
RAGLAND, CHARLES W, KANSAS CITY
RAINBOW-EARHART, KATHRYN A, TOPEKA
RAJEWSKI, RICHARD L, HAYS
RAJU, A S PADMA, TOPEKA
RALSTIN, JAMES H, SHAWNEE MISSION
RAMCHANDANI, A P, ULYSSES
RAMIREZ, AUGUSTO H, PITTSBURG
RAMIREZ, IRENE, PITTSBURG
*RAMOS, MICHAEL, WICHITA
RAMSAY, GRACE A, TOPEKA
RAMSEY, BARTLETT W, TOPEKA
RAMZY, MERIT S, WICHITA
RANDALL, GEORGE R, WICHITA
RANDALL, GORDON R, TOPEKA
RANDLES, MICHAEL J, WICHITA
RANDOLPH III, RICHARD J, SHAWNEE MISSION
RANSDELL, EDGAR C, TOPEKA
RANSOM, JAMES H, TOPEKA
RANSOM, WILLARD B, OTTAWA
RATE, PEGGY S, HUTCHINSON
RATE, ROBERT G, HUTCHINSON
RATHBUN, EDWIN O, LIBERAL
RAUSA JR, FRANCISCO C, WICHITA
RAWCLIFFE JR, ROBERT A, WICHITA
RAY, LARRY D, SHAWNEE MISSION
RAYHACK, JOHN M, KANSAS CITY
RAZEK, HANA A, WICHITA
RAZEK, ZACK A, WICHITA
READ, WILLIAM T, COFFEYVILLE
READER, G WHITNEY, WICHITA
REALS, WILLIAM J, WICHITA
REAZIN, WALTER L, WICHITA
RECKLING, FREDERICK W, KANSAS CITY
REDDI, RAGHUNATH P, WICHITA
REDDY, B N, HILL CITY
REDDY, EASHWER K, KANSAS CITY
REDDY, P JAGANNADHA, HILL CITY
REDDY, SATTI S, DODGE CITY
REDDY, VENUMBAKA C, EL DORADO
REDFORD, JOHN W B, KANSAS CITY
REEB, RONALD JOSEPH, KANSAS CITY
REECE, A THOMAS, GARDNER
REECE, RICHARD J, SALINA
REED, A J, WICHITA
REED, D CRAMER, WICHITA
REED, DAVID O, WICHITA
REED, JAMES S, LAWRENCE
REED, JAMES STEWART, KANSAS CITY
REED, RALPH R, LAWRENCE
REED, WILLIAM RANDALL, WICHITA
REED JR, WILLIAM O, KANSAS CITY
REEDER, STEPHEN M, KANSAS CITY
REESE, JACK D, LIBERAL
REESE, JOHN L, LAWRENCE
REEVES, BRADFORD F, DALLAS,TX
REEVES, CHARLES S, FORT SCOTT
REGIER, LADONNA M, COLBY
REINHARDT-WULF, TAISSIA L, GARDEN PLAIN
REINKING, VICTOR E, TOPEKA
REINTJES, STEPHEN L, SHAWNEE MISSION
REISMAN, MICHAEL ALAN, WICHITA
REISWIG, JEFFREY SCOTT, WICHITA
REISZ, COLLEEN C, SHAWNEE MISSION
REITH, PAUL, LAWRENCE
REITZ, LELAND C, MANHATTAN
REITZ, ROGER P, MANHATTAN
REIVICH, RONALD S, SHAWNEE MISSION
RELIHAN, DONALD A, WICHITA
REMPEL, JOHN H, WICHITA
RENDON, HUMBERTO M, AL AIN,
REPLOGLE, CHARLES B, GREAT BEND
RETHORST, RICHARD D, KANSAS CITY
REUSSER, WAYNE M, WICHITA
REYES JR, FRANCISCO A, OTTAWA
REYMOND, RALPH D, TOPEKA
REYNOLDS, JEFFREY C, HAYS
REYNOLDS, MIKE G, KANSAS CITY
REZAEI, SHIRLEY J, WICHITA
RHOADS, DANIEL D, KANSAS CITY
RHOADS, JAMES P, WICHITA
RHODEN, CURTIS H, WICHITA
RHODES, IVAN E, WICHITA
RHODES, JAMES B, KANSAS CITY
RHODES, LOWELL M, WICHITA
RHODES, MARTIN L, KANSAS CITY
RICCI, ROBERT LAWLER, TOPEKA
RICE, BERNARD F, SHAWNEE MISSION
RICE JR, FREDERICK A, KANSAS CITY
RICH, ELDON S, N NEWTON
RICH, GARY L, KANSAS CITY
RICH, JOSEPH E, TOPEKA
RICHARDS, DALLAS LEE, HAYS
RICHARDS, DENNIS D, CLAY CENTER
RICHARDS, JON F, SALINA
RICHARDSON, CATHERINE A, KANSAS CITY
RICHARDSON, CURTIS J, MARYSVILLE
RICHARDSON, J M, TOPEKA
RICHARDSON, JAY L, KANSAS CITY
RICHARDSON, STEWART F, WICHITA
RICHTER, DON G, SHAWNEE MISSION
RICK JR, GREGORY G, SHAWNEE MISSION
RIDER, JAMES W, ATCHISON
RIEDERER, ROBERT E, WICHITA
RIEGER, ERNEST H, WICHITA
RIEPE, ROGER E, WICHITA
RIESENMY, BRANDON D, SHAWNEE MISSION
RIFFEL, LAWRENCE D, SHAWNEE MISSION
RIGGS, PAUL A, WICHITA
RIGGS, SANDRA L, KANSAS CITY,MO
RIGLER, WILSON F, BURLINGTON
RILEY, RAY B, KANSAS CITY
RINDT, PHILLIP L, FREDONIA
RIORDAN, HUGH D, WICHITA
RIORDAN, TERRANCE, LAWRENCE
RISING, JESSE D, KANSAS CITY
RITCHIE, KAREN S, KANSAS CITY,MO
RIZZA, ROBERT G, HALSTEAD

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ROACH, NEIL E, WICHITA
ROAN, YEAI, WICHITA
ROBERTS, DANIEL K, WICHITA
ROBERTS, RICHARD S, LAWRENCE
ROBERTS, WARREN E, TOPEKA
ROBERTS, ROGER W, O.D., WICHITA
ROBERTSON, EDWARD J, SHAWNEE MISSION
ROBERTSON, JOSEPH K, WICHITA
ROBINSON, DAVID B, TOPEKA
ROBINSON, DAVID W, KANSAS CITY
ROBINSON, EDGAR L, BELLA VISTA,AR
ROBINSON, G DONALD, WICHITA
ROBINSON, JOHN D, SHAWNEE MISSION
ROBINSON, JOHN E, WICHITA
ROBINSON, RALPH G, KANSAS CITY
ROBINSON, RICHARD K, KANSAS CITY
ROBINSON, ROBERT H, WICHITA
ROB_, DAVID A, WICHITA
ROCHANAYON, PIRA, ELLIS
ROCK, RANDAL_ W, WICHITA
RODERICK, JAMES E, SALINA
RODRIGUEZ, BEATRIZ M, SHAWNEE MISSION
RODRIGUEZ, PAUL L, GARDEN CITY
RODRIGUEZ-RAMOS, ERNEST R, WICHITA
RODRIGUEZTOCKER, LILIA, WICHITA
ROEDER, ROBERT E, TOPEKA
ROEMBACH, JEANINE L, TOPEKA
ROMALIS, BRIAN E, WICHITA
ROME, MICHAEL P, KANSAS CITY
ROMEISER, REX S, SALINA
ROMONDO, STEVEN A, OLATHE
RONSICK, STEVEN O, KANSAS CITY
ROOK, LEE E, KANSAS CITY
ROOS, MAUREEN, WICHITA
RORABAUGH, DONALD C, ABILENE
ROSE, DONALD L, BELLA VISTA,AR
ROSE, GRAHAM C, MANHATTAN
ROSE, SHELBY D, WICHITA
ROSEN, CARL H, PRATT
ROSEN, DAVID, WICHITA
ROSENBERG, STANTON L, SHAWNEE MISSION
ROSENBERG, THOMAS F, WICHITA
ROSENTHAL, STANTON J, KANSAS CITY
ROSIN, ROBERT L, WICHITA
ROSS, DAVID K, ARKANSAS CITY
ROSS, DENNIS LEE, WICHITA
ROSS, JACK L, TOPEKA
ROTERT, LARRY, TOPEKA
ROTH, ALAN E, KANSAS CITY
ROTHSTEIN, TERRY B, PARSONS
ROWDON, GREGORY A, SHAWNEE MISSION
ROWLETT, JACK G, PAOLA
ROY, RISE J, KANSAS CITY
ROY, WILLIAM R, TOPEKA
RUBIN, HERBERT M, SHAWNEE MISSION
RUBIN JR, BEN, KANSAS CITY
RUBLE JR, JAMES L, OVERBROOK
RUEB, ANDREW E, SALINA
RUHL, CONSTANCE E, CHANUTE
RUHLEN, JAMES L, OLATHE
RUIZ, CARLOS M, GREAT BEND
RUMOLO, MERVIN J, SHAWNEE MISSION
RUNNELS, JOHN B, TOPEKA
RUPP, RICHARD J, TOPEKA
RUSSELL, BRIAN K, SHAWNEE MISSION
RUSSELL, PHILIP W, WICHITA
RUSSO, LIBBIE J, KANSAS CITY
RUTH, WILLIAM E, KANSAS CITY
RUTNGAMLUG, LUECHA, HAYS
RUZICKA, LAWRENCE J, CONCORDIA
RYAN, MICHAE_ E, SHAWNEE MISSION
RYAN, MICHAEL J, KANSAS CITY
RYAN, SHERRY L, KANSAS CITY
RYMER, ROBERT A, SHAWNEE MISSION
RYSER, CAROL A, KANSAS CITY,MO

S

SABIN JR, GEORGE M, WICHITA
SACHEN, FREDERICK L, SHAWNEE MISSION
SACK, JOSEPH M, WICHITA
SADIQ, SULEMAN, WICHITA
SAEED, MOHAMMAD, WICHITA
SAFFO, KARL S, SHAWNEE MISSION
SALEH, GEORGE A, D.O., KANSAS CITY,MO
SAMPAT, PRAVIN, TOPEKA
SAMUEL, CHANOY C, WINFIELD
SAMUEL, SHANTHI, WINFIELD
SANCHEZ, ROGELIO, TOPEKA
SANDENO, CRAIG A, SHAWNEE MISSION
SANDERS, GLORIA D, WICHITA
SANDERS, J ALAN, LAWRENCE
SANDERS, JAMES E, KANSAS CITY,MO
SANDNESS, KATHLEEN M, KANSAS CITY
SANTOS, FERMIN M, KANSAS CITY
*SANTOS, JOAQUIN G, WICHITA
SANTOSCOY, GILBERT S, WICHITA
SARGENT, JOSEPH O, TOPEKA
*SATHER, R ALAN, WICHITA
SATHYANARAYANA, SARASWATHI, SHAWNEE MISSION
SAUL, F WILLIAM, MECHANICSBURG,PA
SAUNDERS, MICHAEL E, CONCORDIA
SAVIN, VIRGINIA J, KANSAS CITY
SAWKAR, LAXMIDAS A, SHAWNEE MISSION
SAYEED, BASEER A, HAYSVILLE
SAYEGH, JOHN, KANSAS CITY
SAYLER, JEROME, GREAT BEND
SAYLOR, EDWARD H, TOPEKA
SAYLOR, LESLIE L, TOPEKA
SAYLOR, MARK, TOPEKA
SAYLOR, STEPHEN, TOPEKA
SCALES, WILLIAM M, HUTCHINSON
SCAMMAN, W MIKE, TOPEKA
SCANLAN, TIMOTHY M, WICHITA
SCANLAN JR, JAMES H, HADDAM,CT
SCHAEFER, JOSEPH PETER, SHAWNEE MISSION
SCHAFFER, CLARENCE K, SANTA CRUZ,CA
SCHEEL, BRADLEY J, HUTCHINSON
SCHELLINGER, RICHARD P, EMPORIA
SCHERER, ALFRED L, FRITCH,TX
SCHILTZ, FRANCES, WICHITA
SCHIMKE, R NEIL, KANSAS CITY
SCHLACHTER, ERNEST R, WICHITA
SCHLEMMER, ROGER B, PITTSBURG
SCHLICHER, JOHN E, WICHITA
SCHLOESSER, ANNE C, KANSAS CITY,MO
SCHLOESSER, HARVEY L, TOPEKA
SCHLOESSER, PATRICIA T, TOPEKA
SCHLOTTERBACK, WILLIAM E, BELLEVILLE
SCHLUETER, JOHN J, WICHITA
SCHLYER, ARTHUR M, WICHITA
SCHMAUS, LYLE F, IOLA
SCHMEIDLER, DAVID ALLEN, ARKANSAS CITY
SCHMIDT, HERBERT R, NEWTON
SCHMIDT, KENLEY O, GOESSEL
SCHMIDT, MICHAEL J, TOPEKA
SCHMIDT, RAMON WARNER, SALINA
SCHNELLE, JOACHIM, WICHITA
SCHNOEBELEN, RENE E, KINSLEY
SCHNOSE, GREGORY O, LAWRENCE
SCHOELING, RICK D, KANSAS CITY
SCHOPF, CLIFTON C, WICHITA
SCHOWENGERDT, ANDREW W, KANSAS CITY
SCHRAM, PETER CHARLES, TOPEKA
SCHREPFER, ROSEMARY, SHAWNEE MISSION
SCHROEDER, SYDNEY O, LAWRENCE
SCHROFF, GREGORY P, KANSAS CITY
SCHROLL, JACK C, HUTCHINSON
SCHROLL, JOHN T, SHAWNEE MISSION
SCHUETZ, PERRY N, GREAT BEND
SCHUKMAN, JAY S, GREAT BEND
SCHULMAN, STACEY J, KANSAS CITY
SCHULTZ, JAMES E, COUNCIL GROVE
SCHUPP, ELIZABETH A, SHAWNEE MISSION
SCHURLE, DALE R, MCPHERSON
SCHUSTER, MICHAEL R, SHAWNEE MISSION
SCHUYLER, GREGG T, KANSAS CITY
SCHWARTING, J STEVE, ABILENE
SCHWARTZ, EUGENE W, DODGE CITY
SCHWARTZ, V DEAN, WICHITA
SCHWEGLER, RAYMOND A, LAWRENCE
SCHWEGLER, RAYMOND A, KANSAS CITY
SCHWORM, CURTIS P, KANSAS CITY
SCLAR, WILLIAM C, SHAWNEE MISSION
SCOTT, ALEX, JUNCTION CITY
SCOTT, CHESTER E, SALINA
SCOTT, DUANE L, BELLEVILLE
SCOTT, JUDITH C, SHAWNEE MISSION
SCOTT, STEVE G, KANSAS CITY,MO
SCOTT, WILLIAM H, WICHITA
SCROGGIE, DANIEL J, PAOLA
SEAMAN, LAUREN I, OLATHE
SEATON, ROBERT D, SALINA
SEBREE, STEVEN G, SALINA
SEGEBRECHT, STEPHEN L, LAWRENCE
SEGERSON, JOHN A, TOPEKA
SEGLIE, FLOYD RONALD, PITTSBURG
SEGRAVES, STEVEN O, SHAWNEE MISSION
SEHDEV, JOAN, TOPEKA
SEIFERT, EARNEST D, KANSAS CITY
SEITZ JR, JOSEPH E, ELLSWORTH
SEKAVEC, GORDON B, OAKLEY
SELLERS, JEFF D, SHAWNEE MISSION
SEN SARMA, PRONAB K, WICHITA
SERERES, EDGAR P, KANSAS CITY
SETTLE JR, RUSSELL O, OLATHE
SETTLE SR, RUSSELL O, TOPEKA
SEVIER, SAMUEL M, MUSKOGEE,OK
SEYB, STACY T, KANSAS CITY
SHAAD, DOROTHY J, SHAWNEE MISSION
SHAFER, PRESTON J, WICHITA
SHAFFER, KATHLEEN BRAY, SHAWNEE MISSION
SHAFFER, STANLEY G, SHAWNEE MISSION
SHAH, ASHOK H, WINFIELD
SHAH, MIAN, _ARNED
SHAH, MUKHTAR H, WICHITA
SHAH, NASREEN, LARNED
SHAH, SHARFUDDIN, HALSTEAD
SHANKER, STUART G, OLATHE
*SHAPIRO, WILLIAM M, WICHITA
SHARMA, ARUN L, PARSONS
SHARMA, S A, SYRACUSE
SHAW, HOWARD A, KANSAS CITY
SHAW, JOSEPH L, TOPEKA
SHAW, PAMELA K, KANSAS CITY
SHAW, RICHARD C, WICHITA
SHAW JR, JAMES W, HUTCHINSON
SHEAFOR, DOUGLAS, TOPEKA
SHEARS, ROBERT N, HUTCHINSON
SHECHTER, NATHAN, KANSAS CITY,MO
SHEEHAN, MAUREEN H, SHAWNEE MISSION
SHEERN, MARK DOUGLAS, ABILENE
SHEFFER, KEITH O, OLATHE
SHEHI, LORA J, WICHITA
SHELLITO, JOHN G, WICHITA
SHELLITO, JOHN L, WICHITA
SHELTON, STEPHEN E, TOPEKA
SHEPARD, LEROY W, LARNED
SHEPPARD, ROBERT G, SMITH CENTER
SHEPPARD, THOMAS D, WINFIELD
SHERBON, MARY LOU, WICHITA
SHERIDAN, RANDY M, SHAWNEE MISSION
SHERMAN, DENISE I, KANSAS CITY
SHERMAN, ROBERT P, KANSAS CITY
SHERVIN, ADEL, HUTCHINSON
SHERWOOD JR, CLARENCE E, TOPEKA
SHEU, W ERIC, TOPEKA
SHIELD, CHARLES, WICHITA
SHIELDS, THOMAS M, MANHATTAN
SHIELDS JR, JAMES M, EL DORADO
SHIFLET, ALBERT W, WHEELING,MO
SHIVEL, DAVID G, GREAT BEND
SHOFFNER, RICHARD W, WICHITA
SHOFSTALL, WILLIAM H, SHAWNEE MISSION
SHORT, BRUCE H, SHAWNEE MISSION
SHORTES, LOIS E, FT BRAGG,CA
SHRADER, C ERIC, WICHITA
SHRADER, DOYLE A, WICHITA
SHULTZ, WILLIAM H, SHAWNEE MISSION
SHUMARD, CRAIG J, WICHITA
SHURTZ, GLEN L, WICHITA
SIBAI, M ATEF, HUTCHINSON
SIBALA, JUSTO L, PRATT
SIEG, KARL G, KANSAS CITY
SIEGEL, ALBERT R, WICHITA
SIEMENS, CHARLOTTE A, WICHITA
SIEMENS, RICHARD A, LYONS
SIFERS, TIMOTHY M, KANSAS CITY
SIFFORD, R LAWRENCE, WICHITA
SILER, EUGENE T, HAYS
SILLS, CHARLES T, NEWTON
SILLS, THOMAS D, SHAWNEE MISSION
SILVER, BRADD J, SHAWNEE MISSION
SIMMONS, ROBERT EARLE, NEWTON
SIMMS, DAVID ALAN, WICHITA
SIMON, CRAIG A, KANSAS CITY
SIMONY, M ANN, SHAWNEE MISSION
SIMPSON, ROBERT LIMBAUGH, OBERLIN
SIMPSON, TOM C, STERLING
SIMPSON, WILLIAM S, TOPEKA
SINGER, PHILIP A, KANSAS CITY,MO
SINGH, GIRVAR, ARKANSAS CITY
SINNING, GARY, HIAWATHA
SISK, PHILLIP B, TOPEKA
SIWEK, CHRISTOPHER W, EL DORADO
SKAER, STANLEY ALLEN, EUREKA
SKIBBA, RICHARD M, WICHITA
SKIKNE, BARRY S, KANSAS CITY
SKOCH, MICHAEL G, WICHITA
SLAVIK, MILAN, KANSAS CITY,MO
SLOO, MILO G, SALINA
SLUTSKY, LAWRENCE JOEL, WICHITA
SMITH, ALVIN L, WICHITA
SMITH, BOYD E, SALINA
SMITH, BRUCE G, ARKANSAS CITY
SMITH, DALE C, SHAWNEE MISSION
SMITH, DAVID E, SALINA
SMITH, DONALD J, SHAWNEE MISSION
SMITH, HAROLD R, SALINA
SMITH, JOHN D, LARNED
SMITH, JON A, SALINAS, CA
SMITH, LEO A, TOPEKA
SMITH, NEWTON C, ARKANSAS CITY
SMITH, PERRY MILTON, GREAT BEND
SMITH, THOMAS WILLIAM, HUTCHINSON
SMITH, TIMOTHY WM, WICHITA
SMITH, WILLIAM E, KANSAS CITY
SMITH, WILLIAM P, SHAWNEE MISSION
SMITH JR, FLOYD L, COLBY
SMITH JR, WILLARD J, WICHITA
SNARR, JACK W, TOPEKA
SNIDER, BRUCE B, KANSAS CITY
SNODELL, FIRMIN E, SHAWNEE MISSION
SNOOK, ROBERT RUFUS, MCLOUTH
SNOW, DONALD L, LEAVENWORTH
SNOW JR, ARTHUR D, SHAWNEE MISSION
SNOWBARGER, MARVIN O, EMPORIA
SNYDER, GREGG M, WICHITA
SNYDER, H MARTIN, WINFIELD
SNYDER, HOWARD E, WINFIELD
SNYDER, KELVIN K, MANHATTAN
SNYDER, MARK G, KANSAS CITY
SNYDER, RICHARD HENRY, OLATHE
SNYDER, THOMAS E, SALINA
SOELDNER, JAMES D, SHAWNEE MISSION
SOHN, YUNGGYO, TOPEKA
SOLOMON, HERMAN, WICHITA
SOLTZ, ROBERT A, WICHITA
SOMERS, MARVIN M, WICHITA
SOMMERFIELD, DAVID L, KANSAS CITY
SONGER, HERBERT L, ABILENE
SOSINSKI, RICHARD F, LAWRENCE
SOUCEK, CHARLES D, KANSAS CITY
SOUTHERN, FREDRICK N, KANSAS CITY
SPANN, RICHARD W, WICHITA
SPEARMAN, JESSE L, TOPEKA
SPEARS, CHESTER A, EMPORIA
SPEER, LELAND, KANSAS CITY
SPEER, LOUIS N, OTTAWA
SPENCER, JOHN HAROLD, FORT SCOTT
SPENCER, MILLARD C, TOPEKA
SPENCER, WAYNE E, TOPEKA
SPERRY, ROBERT E, SHAWNEE MISSION
SPIKES, MARION E, GARDEN CITY
SPILKER, CYNTHIA A, KANSAS CITY
SPITZER, JEROME S, HUTCHINSON
SPRINGER, MARK J, KANSAS CITY

* Probationary members.

STACEY, KIMBALL, INDEPENDENCE
STADALMAN, ROSS EUGENE, HAYS
STAFFORD, ROBERT W, HUTCHINSON
*STAMBAUGH, ROY A, WICHITA
STAMOS, GEORGE E, SHAWNEE MISSION
STAMPS, PHIL, WICHITA
STANLEY, BRAD K, KANSAS CITY
STANLEY, KENNETH E, WICHITA
STANLEY, REX C, PAOLA
STARK, JAMES R, WICHITA
STARKEY, DAVID J, KANSAS CITY
STARKEY, JERALD _, RUSSELL
STARR, STEVEN K, KANSAS CITY
STASS-ISERN, MERRILL, KANSAS CITY,MO
STECH, JOSEPH M, ANDALE
STECHSCHULTE, DANIEL J, KANSAS CITY
STECKLEY, RICHARD ALLEN, WICHITA
STEEGMANN, A THEODORE, INDIANAPOLIS,IN
*STEELBERG, ELSIE, WICHITA
STEELE, CLARENCE H, KANSAS CITY
*STEELE, ROBERT E, WICHITA
STEICHEN, EDWARD F, LENORA
STEIN, JOSEPH M, TOPEKA
STEIN, PAUL S, WICHITA
STEINBERGER, CRISTINE C, SHAWNEE MISSION
STEINKRUGER, VERLYN WILLIAM, SMITH CENTER
STEINZEIG, SHERMAN M, KANSAS CITY
STEMBRIDGE, TRAVIS W, WICHITA
STENSAAS, CARL O, HUTCHINSON
STEPHANZ JR, GERALD B, WICHITA
STEPHENS, CHARLES, MINNEOLA
STEPHENS, RONALD L, KANSAS CITY
STEPHENSON, LUCILLE C, ST FRANCIS
STEVENS, MILDRED J, GARNETT
STEVENS, PHILIP L, TONGANOXIE
STEVENS, ROBERT L, GARNETT
STEVENSON, E KENT, SHAWNEE MISSION
STEWART, DANIEL L, WICHITA
STINGO, ANDREW J, STILLWELL
STOCK, KARL W, TOPEKA
STOCKWELL, MORGAN U, DODGE CITY
STOFER, BERT E, PRESCOTT,AZ
STOFFER, ROBERT P, HALSTEAD
STOKES, ROBERT LEE, KANSAS CITY,MO
STONE, CHRIS O, KANSAS CITY
STONE, G REX, MANHATTAN
STONE, GRANT C, ATTICA
STOSKOPF, LAWRENCE E, SALINA
STOUT, JAMES M, HUTCHINSON
STOUT, NILES M, LYNDON
STRAIN, LORRAINE L, WICHITA
STREET, DAVID E, WICHITA
STREHLOW, CHESTER H, OTTAWA
STREIT, JEROME G, WICHITA
STRICKLAND, M H VAN, WICHITA
STRIEBINGER, CHARLES M, SHAWNEE MISSION
STRONG, BRADLEY W, KANSAS CITY
STRUTZ, WILLIAM C, LEAVENWORTH
STRYKER JR, HENRY B, CONCORDIA
STUART, SCOTT P, KANSAS CITY
STUBBLEFIELD, CHARLES T, KANSAS CITY
STUBER, JACK LAWRENCE, SHAWNEE MISSION
STUBLER, DANIEL K, KANSAS CITY
STUCKEY, CHARLES E, SHAWNEE MISSION
STUCKY, DEAN E, MEDICINE LODGE
STUEVER, KEVIN J, KANSAS CITY,MO
STUEWE, BRADLEY R, SALINA
STUMP, HARL G, HAYS
SUERO, JESUS T, WICHITA
SUFI, M ASHRAF, TOPEKA
SUGAR, ROBERT L, SHAWNEE MISSION
SUITER, DANIEL JAY, PRATT
SULLIVAN, CORNELIUS J P, WICHITA
SULLIVAN, LEONARD L, WICHITA
SULLIVAN, TOM G, SHAWNEE MISSION
SULLIVAN JR, HENRY B, SHAWNEE MISSION
SUMMERS, LAURIE K, WICHITA
SUMNER, RALPH N, FREDONIA
SURFACE, GARDNER A, ELLIS
SUTTON, JEFFREY J, KANSAS CITY
SUTTON, ROBERT E, INDEPENDENCE
SUTTON JR, RICHARD L, SHAWNEE MISSION
SVOBODA, CHARLES R, CHAPMAN
SVOBODA, LOIS V, WICHITA
SVOBODA, WILLIAM B, WICHITA
SWAN, MAJOR MARTIN, GREAT BEND
SWANN, CLAIR L, RUSSELL
SWARTZ, MARSHA A, WICHITA
SWARTZ, WARREN E, ELMENDARF AFB,AK
SWEET, DONNA E, WICHITA
SWOGGER JR, GLENN, TOPEKA

T

TADURAN, VIRGILIO, SATANTA
TAIT, AMY S, SHAWNEE MISSION
TAIT, LAYNE S, SHAWNEE MISSION
TALLEY, ROBERT L, SHAWNEE MISSION
TANODC JR, VALENTIN T, NEWTON
TANG, CHANTRA, PARSONS
TANG, SAROHD, PARSONS
TAPPEN, DANIEL L, TOPEKA
TARANTINO, CELESTE A, KANSAS CITY
TARGOWNIK, KARL K, TOPEKA
TARNOWER, AMY C, TOPEKA
TARNOWER, WILLIAM, TOPEKA
TARVER, STEPHEN O, WICHITA
TARVIN, RANDY J, SHAWNEE MISSION
TATPATI, DANIEL A, WICHITA
TATPATI, OLGA ADELINA, WICHITA
TAWIL, ELIAS ADIB, PITTSBURG
TAYIEM, A K, ATCHISON
TAYLOR, BARBARA D, MANHATTAN
TAYLOR, E J, HUTCHINSON
TAYLOR, ELMER W, SEDAN
TAYLOR, ONEITA F, KANSAS CITY
TAYLOR, RICHARD J, WICHITA
TAYLOR, SARAH A, KANSAS CITY
TAYLOR, THOMAS F, SALINA
TAYLOR, THOMAS L, SHAWNEE MISSION
TAYLOR, WILLIAM F, KANSAS CITY
TAYLOR, WILLIAM K, WICHITA
TEARE, MARIJO, KANSAS CITY,MO
TEARE, MAX E, GARDEN CITY
TEETER, CAROLYN NAN, KANSAS CITY
TEETER, MARILYN A, KANSAS CITY
TEJANO, NEONILO A, HALSTEAD
TEMPERO, STEPHEN J, TOPEKA
TEMPLETON, ARCH W, KANSAS CITY
TENNY, ROBERT T, SHAWNEE MISSION
TETER, KENNETH E, KANSAS CITY
TETZLAFF, ARCH O A, SHAWNEE MISSION
THEDINGER, BRADLEY S, KANSAS CITY
THELEN, J CHRISTINE, WICHITA
THERDU, LEONA F, KANSAS CITY
THIEMANN, A H, O.D., SUBLETTE
THOMAS, GREGORY MCQUEEN, MCPHERSON
THOMAS, JAMES H, KANSAS CITY
THOMPSON, DANIEL M, WICHITA
THOMPSON, DANNIE M, KANSAS CITY
THOMPSON, JEFFREY D, KANSAS CITY
THOMPSON, SCOTT W, OLATHE
THOMPSON, WILLIAM E, WICHITA
THOMS, NORMAN W, TOPEKA
THOMSEN, GARY, SHAWNEE MISSION
THORNTON, CAROLYN SUE, SHAWNEE MISSION
THORNTON, JAMES L, FORT SCOTT
THORNTON, REBECCA R, SHAWNEE MISSION
THORNTON III, FOXHALL P, KANSAS CITY
THORNTON JR, FOXHALL P, CONCORDIA
THORPE, FRANCIS A, PRATT
THURSTON, DAVID E, TOPEKA
TIEMANN, WILLIAM H, MANHATTAN
TIETZE, DENNIS D, TOPEKA
TIHEN, EDWARD N, WICHITA
TIHEN, HENRY N, WICHITA
TILLER, GEORGE R, WICHITA
TILLOTSON, DON R, ULYSSES
TILTON, FRANK M, WICHITA
TINKER, ROBERT C, WICHITA
TINTEROW, MAURICE M, WICHITA
TIOJANCO, REYNALDO R, KANSAS CITY
TIPPIN JR, ERNEST E, WICHITA
TISDALE, TERRANCE C, HUTCHINSON
TIVORSAK, ARKOM, ATCHISON
TOALSON, WILLIAM B, SHAWNEE MISSION
TOBIAS, ROGER R, LYONS
TOCKER, ALFRED M, WICHITA
TOMPKINS, CARL O, NEWTON
TONG, ROLANDO M, INDEPENDENCE
TONN, GERHART R, WICHITA
TOOHEY, JOHN S, WICHITA
TORREY, ELIZABETH A, KANSAS CITY
TOSH, FRED E, WICHITA
TOTH, JOHN ROY, TOPEKA
TOUT, ROBERT C, MANHATTAN
TOZER, RICHARD C, TOPEKA
TRACY, TERRY A, WICHITA
TRAVERS, HENRY, WICHITA
TRAVIS, JOHN W, TOPEKA
TREES, DONALD P, HOLLYWOOD,CA
TREGER, NEWMAN V, TOPEKA
TREKELL, WILLIAM V, DODGE CITY
TRETBAR, HARVEY A, WICHITA
TRETBAR, LAWRENCE L, SHAWNEE MISSION
TREWEEKE, MICHAEL W, WICHITA
TRIMBLE SR, DAVID P, EMPORIA
TRIMMER, KENNETH J, WICHITA
TROTTER, ROGER COURTNEY, DODGE CITY
TROWBRIDGE, DENISE R, SHAWNEE MISSION
TRUDEAU, DAVID L, WICHITA
TRUEWORTHY, ROBERT C, KANSAS CITY
TRUJILLO, ANTERO A, WICHITA
TSCHOPP, CHARLES F, ANCHORAGE,AK
TSEN, ANDREW C, KANSAS CITY
TUCKER, DONALD R, LAWRENCE
TUCKER, SHERIDAN G, SHAWNEE MISSION
TUCKER, VIRGINIA L, TOPEKA
TUONG, TRAN MANH, AUGUSTA
TURKLE, JANET K, MULVANE
TURNER, JOHN W, GARDEN CITY
TURNER, ROBERT N, KANSAS CITY
TURNER, WADE A, KANSAS CITY
TWEET, FREDRICK A, PITTSBURG
TWEITO, DAVID H, HUTCHINSON
TWEMLOW, STUART W, TOPEKA

U

UBELAKER, ERNEST J, SOUTH HAVEN
UHLIG, PAUL J, WICHITA
UHR, NATHANIEL, TOPEKA
UNDERWOOD, CHARLES C, EMPORIA
UNREIN, ROBERT J, GREAT BEND
UTLEY, JAMES HARMON, KANSAS CITY,MO
UY, WILSON O, COFFEYVILLE

V

VACHAL, EVA, GARDEN CITY
VAKAS, JOHN L, COFFEYVILLE
*VAL-MEJIAS, JESUS E, WICHITA
VALK, WILLIAM L, SHAWNEE MISSION
VAN DOREN, BRYAN A, KANSAS CITY
*VAN ES, GERALD L, WICHITA
VAN HOUDEN, CHARLES E, CHANUTE
VAN LEEUWEN, GERARD J, WICHITA
VAN SICKLE, GREGGORY J, TOPEKA
VAN THULLENAR, PHILIP A, KANSAS CITY
VANDE GARDE, LARRY D, TOPEKA
VANDER VELDE, STANLEY L, EMPORIA
VANNAMAN, DONALD O, SHAWNEE MISSION
VARGHESE, GEORGE, KANSAS CITY
VASUDEVAN, GOPI, KANSAS CITY,MO
VATS, TRIBHAWAN S, KANSAS CITY
VAUGHN, DONNA A, WICHITA
VELARDE, HUGO, KANSAS CITY
VENNEMAN II, CHARLES R, SHAWNEE MISSION
VERMA, ASHA, PARSONS
VERNON, MARY C, LAWRENCE
VESOM, PITT, ATCHISON
VESOM, URAIWAN, ATCHISON
VICHYANOND, PAKIT, PARSONS
VIERTHALER, CARL A, DODGE CITY
VILE, SHELDON B, SHAWNEE MISSION
VILLANUEVA, CESAR L, SHAWNEE MISSION
VIN ZANT, LARRY E, WICHITA
VINE, DONALD LEE, WICHITA
VINZANT, MARK N, DERBY
VINZANT, WHITNEY L, WICHITA
VITALE, NEIL B, KANSAS CITY,MO
VOGEL, STANLEY J, TOPEKA
VOGT, VERNON W, NEWTON
VOLKMANN II, HARLEY W, MANHATTAN
VON LEONROD JR, GEORGE, DIGHTON
VON RUDEN, WILLIAM J, HUTCHINSON
VOORHEES, CARROLL O, LEAVENWORTH
VOORHEES, GORDON S, LEAVENWORTH
VORAN, DAVID A, SHAWNEE MISSION
VORHEES, VICTOR J, WICHITA
VOTAPKA, WILLIAM L, STOCKTON
VOTH, DOUGLAS W, WICHITA
VOTH, ERIC A, TOPEKA

W

WADDELL, BILL D, KANSAS CITY
WADE, EDWARD J, WICHITA
WADE, THEODORE E, LIBERAL
WADE III D.O., WILLIAM E, TOPEKA
WAOUD, ABDUL, WICHITA
WAGENBLAST, HOWARD R, SALINA
WAGGONER, FRANKLIN E, BONNER SPRINGS
WAGNER, LENARD D, LARNED
WALASZEK, SHEILA J, KANSAS CITY
WALCH, J JAMES, FORT SCOTT
WALDORF JR, MELVIN H, GREENSBURG
WALIA, JAG M, TOPEKA
WALKER, ANDY E, KANSAS CITY
WALKER, JACK D, KANSAS CITY
WALKER, MAURICE A, KANSAS CITY
WALKER, NELLIE G, LEES SUMMIT,MO
WALKER, WILLIAM H, ESKRIDGE
WALKER, WILLIAM K, SEDAN
*WALKER, MARSHALL D, D.O., WICHITA
WALL, KEVIN K, MANHATTAN
WALLACE, LEO F, TOPEKA
WALLACE JR, WAYNE O, ATCHISON
WALLING, ADRIAN E, WICHITA
WALLING, ANNE D, WICHITA
WALLS, WILLIAM J, TOPEKA
WALSH, DAVID J, KANSAS CITY
WALSH, THOMAS E, ONAGA
WALTERS, BYRON W, SUN CITY,AZ
WALTERS, WILLIAM DAVID, KANSAS CITY
WALTON, PHILIP D, HORTON
WALTZ, CHARLES A, LEAVENWORTH
WALZ, ROYCE C, TOPEKA
WALZ, THOMAS J, TOPEKA
WAMSLEY, CRAIG A, KANSAS CITY
WANG, SIDNEY W, SHAWNEE MISSION
WANLESS, KIRK M, TOPEKA
WARD, CYNTHIA L, WICHITA
WARD, HOWARD N, TOPEKA
WARD, JAMES A, BELLEVILLE
WARD, LARRY G, WICHITA
WARD, ROBERT L, PRATT
WARD, WENDY L, SHAWNEE MISSION
WARDEN, SUSAN K, KANSAS CITY
WARE, LUCILE M, TOPEKA
WARNER, CLAUDE A, KANSAS CITY
WARREN, LINDA D, HANOVER
WARREN, LLOYD P, WICHITA
*WARREN, MARVIN _, WICHITA
WARREN, ROGER D, HANOVER
WARREN, WIRT A, WICHITA
WARREN JR, JOHN W, WICHITA
WARRICK, DAVID ALAN, TOPEKA
WASHBURN, MICHAEL E, LEAVENWORTH
WATANABE, MASAYO, SHAWNEE MISSION
WATERS, CLARENCE N, SALINA
WATERS, DALE A, TOPEKA
WATTS, GARRETT E, WICHITA
WATTS, HARRY E, HAYS

* Probationary members.

WAXMAN, DAVID, SHAWNEE MISSION
WAXMAN, STEVE W, SHAWNEE MISSION
WEAVER, J ROBERT, WICHITA
WEAVER, JACK O, WICHITA
WEAVER, WALTER O, TOPEKA
WEBB, JAMES R, SHAWNEE MISSION
WEBER, DARRELL J, TOREKA
WEBER, ROBERT W, SALINA
WEBER, WALLACE N, HAYS
WEBER JR, HUGO R, WICHITA
WEBSTER, BOBBY W, WICHITA
WEDDLE, DOUGLAS P, FORT SCOTT
WEDEL, KENNETH O, MINNEAPOLIS
WEDEL, KERMIT G, MINNEAPOLIS
WEIDENSAUL, D N, HUTCHINSON
WEIGAND, JOEL T, WELLINGTON
WEIGEL, JOHN W, KANSAS CITY
WEINGART, JAMES H, SHAWNEE MISSION
WEINMEISTER, DONALD O, KANSAS CITY
WEINSTEIN, GARY L, KANSAS CITY
WEIPPERT, EDWARD J, WICHITA
WEISHAAR, PAUL O, KANSAS CITY
*WELCH, ANNA L, WICHITA
WELCH, JACK W, HALSTEAD
WELCH, LAUREN K, WICHITA
WELCH, MARTIN H, WICHITA
WELCH, MAURA S, WAMEGO
WELL, MICHAEL A, LAWRENCE
WELLER, ELIZABETH B, KANSAS CITY
WELLER, RONALD ALAN, KANSAS CITY
WELLING, RAUL A, SHAWNEE MISSION
WELLS, BRUCE W, WINFIELD
WELLS, MAX MICHAEL, WICHITA
WELLSHEAR, CHARLES C, WICHITA
WELSH, NANCY JANE, TOREKA
WELTMER, ROGER P, BELOIT
WELTON, THOMAS C, SHAWNEE MISSION
WENGER, GREGG O, SABETHA
WENINGER, JOHN H, WICHITA
WERNER, WILLARD F, TRIBUNE
WERTH, DARREL O, HAYS
WERTZBERGER, JOHN, LAWRENCE
WERTZBERGER, KENNETH LYNN, LAWRENCE
WESBROOK, CLYDE W, BELLEVILLE,IL
WESCOE, W CLARKE, NEW YORK,NY
WESSELIUS, LEWIS J, KANSAS CITY,MO
WEST, WILLIAM T, WICHITA
WETZEL, MARK O, KANSAS CITY
WHEELER, DWIGHT E, NEWTON
WHEELER, JAMES A, GREAT BEND
WHEELER, NICKY RAY, WICHITA
WHEELER, PINCKNEY R, WICHITA
WHITACRE, MARC M, WINFIELD
WHITAKER, JAMES A, WICHITA
WHITAKER, MARK A, GARDNER
WHITAKER, REN R, OBERLIN
WHITCOMB, RANDALL W, KANSAS CITY
WHITE, CHARLES A, GREAT BEND
WHITE, CHARLES M, WICHITA
WHITE, DONALD C, COFFEYVILLE
WHITE, FAGAN N, RUSSELL
WHITE, JOHN P, SHAWNEE MISSION
WHITE, R BURNLEY, WINFIELD
WHITE, THADDEUS H, MANHATTAN
WHITE, JOHN P, D.O., PITTSBURG
WHITE, WILLIAM L, PHOENIX AZ
WHITE II, BENJAMIN E, EL DORADO
WHITEHEAD, RICHARD E, SHAWNEE MISSION

*WHITESIDE, WILLIAM H, WICHITA
WHITFIELD, STEVEN S, KANSAS CITY
WHITLEY, DOUGLAS M, SHAWNEE MISSION
WIEGMAN, HUGH ALAN, HAYS
WIEGMANN, THOMAS B, KANSAS CITY,MO
WIEN, STEVEN M, SHAWNEE MISSION
WIENS, J WENDELL, NEWTON
WIENS, JONATHAN G, KANSAS CITY
WIENS, LYNN A, KANSAS CITY
WIENS, TIMOTHY K, NEWTON
WIGGINTON, GERALD D, D.O., SHAWNEE MISSION
WIGGLESWORTH, ANNE, WAMEGO
WIGGS, JAMES W, GREAT BEND
WIKOFF, DONALD L, GREAT BEND
WILCOX, DONALD E, TOPEKA
WILCOX, ROBERT N, WICHITA
WILCOX JR, HOWARD L, HAYS
WILCOX SR, HOWARD L, LAWRENCE
WILDER, LOWELL W, WICHITA
WILDS, CHARLES E, BELLA VISTA,AR
WILEY, HORACE M, GARDEN CITY
WILEY, JOHN H, SHAWNEE MISSION
WILEY, THOMAS M, SHAWNEE MISSION
WILKINS, JAMES T, GIRARD
WILKINSON, LARRY K, WICHITA
WILLIAMS, CARL M, SHAWNEE MISSION
WILLIAMS, CHARLES L, WICHITA
WILLIAMS, EVAN R, MESA,AZ
WILLIAMS, HOMER J, OSAGE CITY
WILLIAMS, NANCY J, KANSAS CITY
WILLIAMS, RONALD P, WICHITA
WILLIAMS, THOMAS A, SHAWNEE MISSION
WILLIAMS JR, STERLING B, KANSAS CITY
WILLIAMSON, JOHN, HUTCHINSON
WILLIAMSON, STEPHEN K, WICHITA
WILLNER, CATHERINE, WICHITA
WILNER, JAY, SHAWNEE MISSION,MO
WILSON, H RANDOLPH, HALSTEAD
WILSON, MARVIN H, TOREKA
WILSON, ROBERT B, SHAWNEE MISSION
WILSON, ROBERT L, VALLEY CENTER
WILSON, SLOAN J, SHAWNEE MISSION
WIN, AYE M, DODGE CITY
WINBLAD, J KENT, WINFIELD
WINBLAD, JAMES N, WINFIELD
WINBLAD, JOHN M, WINFIELD
WINCHESTER, EUGENE B, WICHITA
WINGER, RAYMOND E, HUGOTON
WISDOM, JAY K, WICHITA
WISE III, JOSEPH EDWARD, KANSAS CITY
WISNER JR, HARRY J, WICHITA
WISNER JR, JOHN HENRY, KANSAS CITY
WITTMANN, ALBERT F, WICHITA
WOLF, CURTIS V, LYONS
WOLF, KARL T, KANSAS CITY
WOLF, PATRICK G, CONCORDIA
WOLFE, BRIAN D, IOLA
WOLFE, FREDERICK, WICHITA
WOLFF, FREDERICK P, PRATT
WOLKOFF, COR A STARK, BARBERS POINT,HI
WOLLMANN, MARTIN, LAWRENCE
WOOD, EDWARD RUSSELL, TOPEKA
WOOD, FRED M, SHAWNEE MISSION
WOOD, GARY B, WICHITA
WOOD, ROBERT D, WICHITA
WOODHOUSE, CHARLES L, WICHITA
WOODRING, CATHY S, WICHITA
WOODROOF, JANET M, KANSAS CITY
WOODS, DENNIS D, SHAWNEE MISSION
WOODS, GREGORY A, SHAWNEE MISSION
WOODS, HUGH J, SMITH CENTER

WOODS, MICHAEL S, SHAWNEE MISSION
WOODS, ROBERT P, TOPEKA
WORSING JR, ROBERT A, WICHITA
WORTMAN, JACK A, HUTCHINSON
WRAY, ALEXANDER J, WICHITA
*WRAY JR, REGINALD D, WICHITA
WRIGHT, CHRISTOPHER, KANSAS CITY
WRIGHT, KENDALL M, EMPORIA
WRIGHT, MICHAEL J, KANSAS CITY
WRIGHT, STANLEY E, JUNCTION CITY
WRIGHT, TIMOTHY F, KANSAS CITY,MO
WRIGHT III, ROBERT W, SHAWNEE MISSION
WU, JIN-TZE, WICHITA
WULFF, EDWIN T, ATCHISON
WURSTER, GEORGE R, SHAWNEE MISSION

Y

YAGHMOUR, TALAAT E, PITTSBURG
YE, RICHARD C, SHAWNEE MISSION
YEH, ROBERT M, TOPEKA
YEOMANS, RONALD N, OLATHE
YEW, CLAIRE S, WICHITA
YOACHIM, ROBERT W, ARKANSAS CITY
YOCKEY, CHARLES C, WICHITA
YODER, EMERSON D, DENTON
YODER, VERNON E, HESSTON
YOHE, RUTH M, SHAWNEE MISSION
YOON, CHANG SUP, WICHITA
YORKE JR, CRAIG H, TOPEKA
YOST JR, JOHN G, KANSAS CITY,MO
YOUN, HWAN, GREAT BEND
YOUNG, CHARLES H, ATCHISON
YOUNG, DOUGLAS L, WICHITA
YOUNG, JOHN W, SHAWNEE MISSION
YOUNG, PAUL E, TOPEKA
YOUNG, THEODORE E, TOPEKA
YOUNGBERG, DEAN I, WICHITA
YULICH, JOHN D, SABETHA

Z

ZABEL, KENNETH P, PITTSBURG
ZACHARIAS, CARL KURT, DODGE CITY
ZACHARIAS, DAVID LLOYD, TOPEKA
ZACK, ASHLEY S, SHAWNEE MISSION
ZAINALI, ASSADOLLAH, LIBERAL
ZAMIEROWSKI, DAVID S, SHAWNEE MISSION
ZAREMSKI, SHERMAN C, KANSAS CITY
ZARNOW, HILARY, WICHITA
ZATZKIN, JAY B, WICHITA
ZECHMANN, JEROME R, KANSAS CITY
ZELLER, MYRON J, GARDEN CITY
ZERICK, LYLE F, WICHITA
ZIEGLER, DEWEY K, KANSAS CITY
ZIEGLER, JUDY P, WICHITA
ZIMBELMAN, ROD D, KANSAS CITY
ZIMMERMAN, DANIEL D, SHAWNEE MISSION
ZIMMERMAN, KENNETH D, WICHITA
ZIMMERMAN, WILLIAM H, TOPEKA
ZINN, THOMAS W, KANSAS CITY
ZONGKER, PHILIP E, WICHITA
ZURITA, MARCOS, GREAT BEND

* Probationary members.

Medical Specialty Codes Used in This Directory

A	Allergy
ADL	Adolescent Medicine
ADM	Administrative Medicine
ADT	Addictionology
AM	Aviation Medicine
ANES	Anesthesiology
BLB	Blood Bank
CD	Cardiovascular Disease
CDS	Cardiovascular Surgery
CDTS	Cardiovascular & Thoracic Surgery
CHP	Child Psychiatry
CP	Clinical Pharmacology
D	Dermatology
DR	Diagnostic Roentgenology
EENT	Eye, Ear, Nose and Throat
EM	Emergency Medicine
END	Endocrinology
ENT	Ear, Nose, Throat
ES	Endoscopy Surgery
FM	Family Medicine
FP	Family Practice
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GPVS	General & Peripheral Vascular Surgery
GS	General Surgery
GYN	Gynecology
HEM	Hematology
ID	Infectious Diseases
IE	Insurance Examination
IM	Internal Medicine
MFM	Maternal Fetal Medicine
N	Neurology
NEO	Neonatology
NEP	Nephrology
NM	Nuclear Medicine
NOTO	Neuro-otology
NP	Neuropsychiatry
NR	Nuclear Radiology
NS	Neurological Surgery
OBG	Obstetrics and Gynecology
OM	Occupational Medicine
ON	Oncology
OPH	Ophthalmology
ORS	Orthopedic Surgery
OST	Osteopathy
OTO	Otorhinolaryngology
P	Psychiatry
PATH	Pathology
PD	Pediatrics
PDA	Pediatric Allergy
PDC	Pediatric Cardiology
PDE	Pediatric Endocrinology
PDN	Pediatric Neurology
PDNE	Pediatric Nephrology
PDO	Pediatric Ophthalmology
PDS	Pediatric Surgery
PGER	Psychogerontology
PH	Public Health
PM	Physical Medicine & Rehabilitation
PS	Plastic Surgery
PUD	Pulmonary Disease
PYM	Psychosomatic Medicine
R	Radiology
RHU	Rheumatology
RM	Rehabilitative Medicine
RT	Radiation Therapy
SM	Sports Medicine
SON	Surgical Oncology
TR	Therapeutic Radiology
TS	Thoracic Surgery
U	Urology
00	Retired

Physician Distribution by Cities

EXPLANATION OF CODES USED IN THIS SECTION

Line 1: Doe, John R., 1234 Oak St., 67052
(Name) (Street Address) (Zip Code)

Line 2: (654-2222)
(Telephone Number)

Line 3: 33 M 1902 58 FP
(Year of Birth) (Sex) (Medical School) (Year of Graduation) (Specialty)

Telephone area code follows city name. * Probationary Members

ABILENE—913
(Dickinson County Society)

BERKLEY, DON H, 1111 N BRADY,67410
263-4131
35 M 1902 61 FP
BIGGS, DENNIS, 1405 N CEDAR,67410
263-7190
48 M 1902 74 FP
CHAFFEE, DEAN C, RR 1,67410
-
11 M 1902 44 OO
COLEMAN, GARY, 1405 N CEDAR,67410
263-7190
46 M 1902 72 FP
MOHLER, JACK M, 515 NE TENTH,67410
263-1419
32 M 1902 61 PM
NARCISO, VICENTE O, 515 NE 10TH ST,67410
263-2253
45 M 74810 68 GS
RORABAUGH, DONALD C, PROFESSIONAL BLDG,67410
263-4131
33 M 1902 58 FP
SCHWARTING, J STEVE, 1405 N CEDAR,67410
263-7190
46 M 3401 72 FP
SHEERN, MARK DOUGLAS, 1111 N BRADY,67410
263-4131
51 M 1902 76 FP
SONGER, HERBERT L, 1007 SPRUCEWAY,67410
-
12 M 1902 38 OO

ALMA—913
(Pottawatomie County Society)

MCKNIGHT, ELLIS B, ,66401
765-3317
03 M 1902 33 FP

ALTAMONT—316
(Labette County Society)

JACKSON, VICTOR L, BOX 467,67330
784-5318
20 M 2105 50 FP

ANDALE—316
(Sedgwick County Society)

GOODWIN, MARY K, 328 MAIN,67001
267-0865
53 F 1902 77 FP
STECH, JOSEPH M, ANDALE CLINIC,67001
445-2152
27 M 3006 56 FP

ANTHONY—316
(Tri-County Society)

ANTRIM, PHILIP JENIFER, 1101 E SPRING,67003
842-5144
15 M 1902 42 FP

ARKANSAS CITY—316
(Cowley County Society)

ALVAREZ, NORBERTO, 112 E CENTRAL,67005
442-4850
27 M 27501 53 FP
AUCAR, ALFREDO, BOX 1105,67005
442-1710
23 M 27501 53 OTO
CAMPBELL, GARLAND L, 114 W WALNUT,67005
442-1350
13 M 1902 40 U
HILL, JAMES E, 1019 N SECOND,67005
-
09 M 1902 34 OO
HINSHAW, EDGAR D, RT 4 BOX 74,67005
442-1273
15 M 1902 51 R
LEIKER, JOSEPH, 112 E CENTRAL,67005
442-7900
48 M 1902 73 IM
MARVEL, JAMES EBBERT, 2545 N GREENWAY PO BOX873,67005
442-0222
43 M 3901 72 ORS
MORTON, ROBERT A, AC OFFICE BLDG,67005
442-0370
51 M 1902 73 IM
OLD, JERRY L, PO BOX 1148,67005
442-2100
49 M 1902 74 FP
PEREIRA, WILLY G, 2508 EDGEMONT DR,67005
442-8540
39 M 73701 67 IM
ROSS, DAVID K, PO BOX 1148,67005
442-2100
48 M 1902 75 FP
SCHMEIDLER, DAVID ALLEN, 510 W RADIO LANE,67005
442-2100
54 M 1902 79 FP
SINGH, GIRVAR, 2508 EDGEMONT DR,67005
442-4300
40 M 49555 64 OPH
SMITH, BRUCE G, 115 E RADIO LANE,67005
442-5600
20 M 1902 44 IM
SMITH, NEWTON C, PO BOX 1148,67005
442-2100
21 M 3901 45 FP
YOACHIM, ROBERT W, 510 W RADIO LANE,67005
442-2100
52 M 3005 78 FP

ASHLAND — 316
(Iroquois County Society)

OION, MARK WM, 529 W SEVENTH,67831
51 M 702 77 GP

ATCHISON—913
(Atchison County Society)

80SSE, FRANK K, 1301 RIVERVIEW ORIVE,66002
09 M 2802 33 00
BURKE, JOSEPH V, 1400 N SECONO,66002
367-5496
35 M 3006 66 GS
OUNLAP, MICHAEL O, 1120 S FOURTH,66002
367-0362
53 M 1902 79 FP
EPLEE, JOHN R, 1225 N SECOND,66002
367-0362
53 M 1902 78 FP
FAST, ROBERT E, 1225 N 2NO,66002
367-0362
48 M 1902 74 OBG
FAST, W SPENCER, 1301 NORTH SECOND,66002
367-7417
11 M 3006 39 FP
GROWNEY, JOHN T, 801 ATCHISON,66002
367-5020
37 M 3006 63 FP
HART, LAWRENCE E, 1412 N 2ND,66002
367-5054
32 M 1902 64 FP
MILLER, TODO A, 1225 N SECOND,66002
367-0362
55 M 1902 81 FP
MORRISON, IRA R, 825 N 10TH,66002
07 M 1611 36 IM
RIDER, JAMES W, 1225 N 2ND ST, 66002
367-0362
47 M 2803 73 FP
TAYIEM, A K, 1225 N SECONO,66002
367-1114
43 M 33002 62
TIVORSAK, ARKOM, PO 80X 127,66002
367-2131
40 M 89101 68 R
VESOM, PITT, 1301 N SECONO,66002
367-3100
49 M 89104 74 CO
VESOM, URAIWAN, 1301 N SECONO,66002
367-3100
51 F 89104 74 PATH
WALLACE JR, WAYNE O, 1301 N THIRO,66002
367-7300
36 M 2803 65 FP
WULFF, EOWIN T, 923 N FIFTH,66002
367-5033
07 M 2834 36 FP
YOUNG, CHARLES H, 1301 N 3RO,66002
367-4053
23 M 1902 53 FP

ATTICA—316
(Tri-County Society)

STONE, GRANT C, 500 N HARPER,67009
254-7219
08 M 5605 35 FP

ATWOOD—316
(Northwest Kansas Society)

OILL, ROONEY, PO 80X 67,67730
626-3229
41 M 74811 77 GP
ERBACHER, GEORGE E, O.O., PO 80X 203,67730
626-3238
51 M FP

AUGUSTA—316
(Butler-Greenwood Society)

ANOERSON, OALE W, 120 W JOSEPHINE,67010
775-5432
30 M 1902 55 FP
BARBER, JAMES L, 120 W JOSEPHINE,67010
775-5432
31 M 1902 57 FP
FANNING, JANET L, 602 STATE,67010
775-1186
57 F 1902 82 FP
FANNING, KYLE W, 602 STATE,67010
775-1186
56 M 1902 82 FP
TUONG, TRAN MANH, 120 W JOSEPHINE,67010
775-5432
39 M 94101 65 FP

BASEHOR—913
(Wyandotte County Society)

8URGER, WILLIAM E, ROUTE 1,66007
21 M 3006 51 00

BAXTER SPRINGS—316
(Cherokee County Society)

ALQUIST, VERYL O, 21ST & FAIRVIEW,66713
623-4942
17 M 1902 42 GS
CHUBB, RICHARD M, 445 E 10TH, 66713
856-2144
29 M 1606 54 FP

BELLEVILLE—913
(Republic County Society)

OOU8EK, HER8ERT O, PO 80X 250,66935
527-2237
28 M 1902 56 FP
SCHLOTTER8ACK, WILLIAM E, 1202 L,66935
378-3511
31 M 1902 61 FP
SCOTT, OUANE L, BELLEVILLE CLINIC,66935
527-2217
34 M 1902 60 FP
WARD, JAMES A, 1206 18TH ST,66935
527-2217
34 M 1902 58 FP

BELOIT—913
(Mitchell County Society)

OO8RATZ, RO8ERT A, 310 W 8TH,67420
738-2246
24 M 1902 52 FP
ORAKE, OOUGLAS J, MEOICAL CENTER,67420
738-2246
43 M 1902 71 FP
KLENDA JR, MARTIN 8, 8ELOIT MED CENTER,67420
738-2246
38 M 1643 63 GS
LONEY, JOHN M, 310 WEST 8TH,67420
738-2246
50 M 1902 74 IM
WELTMER, ROGER P, 112 W MAIN,67420
18 M 1902 44 00

BLUE RAPIDS—913
(Northeast Kansas Society)

OUENSING, KENNETH L, O.O., PO 80X 127,66411
226-7202
54 M 2878 82 GP
LAWLESS, HAROLO L, PO 80X 127,66411
226-7202
29 M 702 54 FP

KMS

KANSAS MEDICAL SOCIETY

Newsletter

1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

GUST 1985

LPRACTICE COSTS NTINUE CLIMB

As expected, the cost of malpractice insurance continues to increase at an alarming rate. Most Kansas physicians are paying 65-75% more than last year, with some specialties, such as OB-GYN, increasing as much as 100%. A family physician doing some surgery and OB will likely pay $8,000-$12,000 this year. A general surgeon can expect a bill in the $25,000-$40,000 range. An obstetrician will pay $35,000-$50,000 for coverage. For those physicians unlucky enough to be in the JUA serviced by Western Casualty Company, rates averaged 20-60% higher.

The higher rates are reflecting a horrible loss experience among insurance companies nationwide. There is considerable pessimism among insurers that conditions will improve soon, unless tort reform efforts are successful. Many malpractice insurance companies are severely restricting their underwriting, as reserves are jeopardized by accelerating losses. The net result is a very selective primary market, a complete collapse of the reinsurance or excess market, and rapidly increasing premiums to fund anticipated losses.

In Kansas the next twelve months are critical. Decisive action by the 1986 Legislature is essential. The Interim Study Committee has had three fact-finding meetings thus far, and can be expected to start making some preliminary recommendations by mid-October. As expected, the state's most affluent and politically active lawyer's organization, the Kansas Trial Lawyers Association, is opposing any reform. The Kansas Bar Association, which historically has had little political clout compared to the smaller KTLA, has also lined up against the KMS/KHA tort reform effort. The KTLA wields such influence that only a handful of the state's 5,000 lawyers have spoken out in favor of any tort reform. The Kansas Association of Defense Counsel is one such group, which has a somewhat more progressive view. Ironically, several prominent defense lawyers who represent physician and hospitals have forcefully lobbied against the KMS/KHA tort reform proposals. In the complex malpractice mosaic, the difference between advocate and adversary is, unfortunately, a very thin line.

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Professional Liability Update
Conference Announcements:
- Medical Staff
- Alternatives to Tort System
- Communicatons/PR
- Women in Medicine

Medicare Update
Indemnity Pay & RVS
Alzheimer's Disease Research
AARP Involvement Urged
Federal Legislation on Physician Discipline

S SEMINAR ON DICAL STAFF EDENTIALING tober 4, 1985 Wichita

Get answers to tough questions about medical staff privileges especially as they relate to such issues as prospective payment, competition, new JCAH standards, and new legal precedents. Register now for this one-day seminar to be held at the Wichita Airport Hilton Inn on October 4. Faculty: Richard E. Thompson, M.D. and Linda Haddad, Attorney. For information on registration, contact the KMS office at 1-800-332-0156.

MEDICARE UPDATE

Congress went into its long summer recess recently after finall approving an FY-1986 budget that for the short run, at least, concluded months of political wrangling and general polarizatic along party lines. Under the agreement $55 billion would be cu from expenditures, resulting in a mammoth $172 billion deficit. The plan also fell short of reaching President Reagan's beginning-of-the-year goal of halving budget deficits to $100 billion, or less, by FY-1988. Anticipated outlook for that yea now is a $112 billion shortfall. Made on the eve of the Congressional recess, the accord left considerable breakage in its wake. Senate Republican leaders were miffed that President yanked the rug from under them on their proposal to freeze cost of-living benefits under Social Security and military pensions. House Democratic leaders were pleased with that aspect since th had decided to make unabated raises in these benefits a key par of their 1986 Democrat Election platforms. They, however, were unhappy about having to accept increased defense spending as a trade-off.

With time running out on the October 1 deadline for physicians to make their Medicare determinations on whether to be "participating" or "non-participating" under the second year of the Deficit Reduction Act concept, physicians still don't have the decision-making information they need since final action ha not yet been taken. Under differing proposals adopted by two committees the House would continue the fee freeze for another year on non-participating physicians. A House Ways and Means Committee proposal would grant reimbursement increases to participating physicians. Under the approach adopted by the Energ and Commerce Committee new reimbursement tiers would be established. The prevailing charge would be increased at the FULL economic index rate for those physicians who:

- --are currently "participating" and who continue to do so beginning October 1, 1985; and
- --are currently "non-participating," but who opt into the program on October 1, 1985.

The prevailing charge would be increased by ONE-HALF of the ecc nomic index rate for those physicians who:

- --are currently "participating," but who opt out of the program beginning October 1, 1985; and
- --are currently "non-participating" and continue to remain s on October 1, 1985, but are accepting assignment on 100% c their Medicare claims.

Shortly after Congress returns from the recess on September 4, the Senate Finance Committee is expected to consider the Medicare fee freeze and participating/non-participating physician issues. Those and other budget matters likely will have t be resolved in a House-Senate conference. Because of the urgen time constraints on physician decision-making, KMS will prepare a special mailing to help you understand the Medicare changes just as soon as Congress acts.

DEMNITY PAY & RVS

The AMA House of Delegates will seek to implement an indemnity payment system by which third-party payers will agree to pay a set amount for a particular procedure. The delegates registered opposition to any type of national mandatory fee schedule, but endorsed the concept of a relative value study (RVS) to be developed by the medical profession. The AMA has chosen Harvard University to apply for a HCFA grant to develop an RVS system to be based on resource costs of providing physicians' services under Medicare. The project is expected to get under way this fall. The system would allow for geographic differences in cost of practice and would allow the physician to collect the difference between actual charge and third party payment, although the government might impose a balance billing cap. Many physicians feel this is the best alternative to a physician DRG payment system or a national mandatory fee schedule for physician reimbursement under Medicare.

IE NEW LEADERSHIP

Catherine Willer, KU Medical Student, is one of seven students nationwide to be elected to the AMA Council on Medical Educatio Liaison Committee.

) RESEARCH GRANTS 'AILABLE

The National Institute of Mental Health seeks applications for studies on family stress related to the care of those with Alzheimer's Disease (AD) and the development of family care and service delivery models. For further information, contact Enid Light or Barry D. Lebowitz, Ph.D., Center for Studies of the Mental Health of the Aging, National Institute of Mental Health, 5600 Fishers Lane, Rockville MD 20857; 301-443-1185.

MEDICAL MALPRACTICE: The New Options

SEPTEMBER 6, 1985

Sponsored by: The Kansas Medical Society, The Kansas Chapter of the American College of Surgeons, The Kansas Academy of Family Physicians, Stormont-Vail Regional Medical Center

A one-day seminar featuring an international faculty, on alternatives to the current tort system for resolving medical malpractice claims, will be presented at the Pozez Education Center, Stormont-Vail Regional Medical Center, Topeka. Sir Owen Woodhouse, President, Court of Appeal, Wellington, New Zealand and Richard Smith, Assistant Editor, British Medical Journal, London, England, both experts on alternative compensation systems will highlight the conference. Senator Dempsey Barron, Chairman of Florida's Select Committee on Tort Reform will also discuss his proposals for alternatives to the tort system.

The seminar begins at 8:30 a.m. and will end at 4:30 p.m. It has been accredited for 6 hours of Category I CME. Registration cost is $50.00. For information to register, contact the Kansas Medical Society at 1-800-332-0156, or the Department of Educational Service, Stormont-Vail Regional Medical Center, 913-354-5825.

RAUD BILL
HR-1868

A bill to strengthen government authority to exclude disciplined physicians from Medicare and Medicaid practice is advancing in the House of Representatives. At present, physicians who lose a license to practice in one state or who are barred from one federal program cannot be excluded from practice in another state or from another federal program. HR-1868 would give the Department of Health and Human Services the authority to exclude from any federal program any provider who: was convicted of abusing program finances, patients, or controlled substances; lost or surrendered his/her license for cause in any state; provided excessive or poor quality care. If the provider was convicted of a criminal act against Medicare or one of its patients, the minimum period of the exclusion would be five years. The AMA supports the aim of the bill, but doesn't concur with all of its provisions.

Two other bills were incorporated in HR-1868. One--opposed by the AMA--would allow the Attorney General to revoke the drug prescribing authority of any physician banned from Medicare and Medicaid. The other--supported by the AMA--would authorize civil and monetary penalties against anyone who misrepresents him- or herself as a physician.

Similar legislation has been introduced in the Senate but has not been heard in committee. The Reagan administration is reportedly planning to introduce its own fraud and abuse measure in the Senate.

NATIONAL
IGHT-SAVING
MONTH

The National Society to Prevent Blindness has designated September a time to alert the public to the value of early detection of eye problems, proper eye care and the need for eye safety.

ATIONAL COMMUNICATIONS
WORKSHOP - CHICAGO
ctober 31 - November 1

Survey data show that Americans are losing faith in physicians. A dynamic and impressive faculty will lead discussion on all aspects of public relations, and an optional spokesperson training session. INFO: Marilyn Canna, AMA, 312-645-4413.

ONFERENCE ON
OMEN IN MEDICINE

The second Midwest Regional Conference on Women in Medicine is being planned for September 27-29, 1985 in Kansas City. The conference is open to all physicians and medical students with a focus on the role of women in medicine and how they work together with others in all facets of medical practice. For further information, contact Lillian Gonzalez-Pardo, M.D., Associate Professor, Dept. of Pediatrics & Neurology, UKSM-KC, Kansas City KS 66103; 913-588-4488.

MERICAN ASSOCIATION
OF RETIRED PERSONS

AARP is a voice that is being heard by lawmakers when health care matters are being considered. Kansas physicians who are eligible should consider joining this organization in order to understand the problems and be involved in the solutions. Membership is open to those age 50 years and over for $5.00 per year which covers both member and spouse. To join or to request information, write to: American Association of Retired Persons, P.O. Box 2400, Long Beach CA 90801-9988.

BONNER SPRINGS—913
(Wyandotte County Society)

OETAR NEWBERT, LE ANNE, PO BOX 41,66012
-
51 F 1902 87
MAY, KENNETH L, PO BOX 293,66012
422-2020
20 M 1902 51 FP
MITTS, ERNEST W, 122 N NETTLETON, 66012
422-2020
22 M 1902 51 FP
WAGGONER, FRANKLIN E, 122 N NETTLETON, 66012
422-2020
26 M 1902 61 FP

BUHLER—316
(Reno County Society)

FRIESEN, ORLANOO J, 107 W 2NO,67522
543-2330
27 M 1902 56 FP

BURLINGAME—913
(Shawnee County Society)

RIGLER, WILSON F, RR #1 BOX 395,66839
347-8619
42 M 1803 69 FP

CALDWELL—316
(Tri-County Society)

KINNAN, L F, 523 S MARKET,67022
845-6422
18 M 3901 42 FP

CANEY—316
(Southeast Kansas Society)

MOORE, ROBERT F, 4TH & MCGEE,67333
879-2135
28 M 1902 56 FP

CEDAR VALE—316
(Southeast Kansas Society)

COHNBERG, ROSELLEN E, PO BOX 398,67024
758-2266
22 F 2802 47 FP

CHANUTE—316
(Southeast Kansas Society)

ABBUEHL, DON R, 932 WINDSOR,66720
-
18 M 1902 44 00
ASHLEY, SAMUEL G, 505 SOUTH PLUMMER,66720
431-2500
16 M 1902 43 FP
BAKER, HENRY K, 1220 W FOURTH,66720
-
08 M 1606 35 00
BURKMAN, REUBEN J, 1501 W 7TH,66720
431-9310
28 M 1902 54 FP
GEHRT, EARL B, 505 SO PLUMMER,66720
431-2500
32 M 1902 62 FP
HASKINS, ROBERT J, 505 S PLUMMER,66720
431-2500
46 M 1902 74 FP
KIHM, ALBERT A, 505 S PLUMMER,66720
431-2500
27 M 1902 55 FP
MABEN, PAMELA S, 505 S PLUMMER,66720
431-2500
54 F 1902 79 IM
MIH, ALEXANDER, 1002 WEST 4TH,66720
473-2227
22 M 24209 47 ANES
PARHAM, VERDON W, 505 S PLUMMER,66720
431-2500
47 M 1902 73 FP
RUHL, CONSTANCE E, 1114 W FIFTH,66720
-
54 F 1902 86
VAN HOUDEN, CHARLES E, 505 S PLUMMER,66720
431-2500
52 M 1902 77 GS

CHAPMAN—913
(Dickinson County Society)

SVOBODA, CHARLES R, 413 N MARSHALL,67431
922-6400
18 M 1902 46 FP

CHETOPA—316
(Labette County Society)

PEFFLY, ELMER D, 327 MAPLE,67336
236-7188
22 M 3901 53 FP

CIMARRON—316
(Ford County Society)

MC FARLAND, GRETA S, ,67835
-
F

CLAY CENTER—913
(Clay County Society)

ANDERSON, SEVERT A, 1749 BERGLUND DR,67432
-
07 M 1902 36 00
BOGNER, PAUL F, PO BOX 520,67432
632-2181
52 M 1902 77 GS
BRYANT, R KEVIN, PO BOX 520,67432
632-2181
54 M 515 79 FP
DALUM, PETER JOSEPH, PO BOX 520,67432
632-2181
45 M 2803 76 FP
GOOD, MICHAEL W, PO BOX 520,67432
632-2181
53 M 1902 78 FP
O'DONNELL, RICHARD H, PO BOX 806,67432
632-3101
16 M 1902 41 GS
RICHARDS, DENNIS O, 115 S 6TH,67432
632-5621
34 M 1902 60 FP

CLYDE—913
(Cloud County Society)

COULTER, THAYNE A, O.D., 306 N HIGH,66938
-
12 M 2878 37 00
FREEBORN JR, WARREN S, ,66938
446-2221
26 M 1720 51 FP

COFFEYVILLE—316
(Southeast Kansas Society)

BANKS, GILBERT, PO BOX 257,67337
251-7500
49 M 2401 75 IM
CAMPBELL, WILLIAM H, 1411 W 4TH,67337
251-3235
39 M 1902 65 OPH
COYLE, JOHN F, 2600 EDGEVALE,67337
251-0633
21 M 1902 44 FP
DICKINSON, CHARLES R, 108 W 7TH,67337
251-1340
20 M 1606 44 GS
DIXON, RAYMOND W, 1411 W 4TH,67337
251-1090
46 M 4706 71 GS
EDROZO, M LUZ LUNA, 109 W 7TH ST,67337
251-1200
44 F 74801 68 PATH

GIBBS, EUGENE, PO BOX 716,67337
251-7260
M 64914 68 FP
HA, SANG W, 504 WILSHIRE,67337
251-7750
35 M 58309 60 OBG
HAN, CHAN S, 908 SIGGINS,67337
251-1560
35 M 58306 61 PO
HOWERTER JR, BERNARD E, PO BOX 659,67337
251-4790
43 M 1803 68 U
JIRICKO, MILOS, 2510 W EIGHTH,67337
251-1200
37 M 28601 61 ANES
READ, WILLIAM T, 807 MAPLE,67337
251-1120
16 M 2802 40 FP
UY, WILSON O, COFFEYVILLE MEM HOSPITAL,67337
251-1200
42 M 74801 67 PATH
VAKAS, JOHN L, 1508 W 4TH,67337
251-3443
38 M 1902 64 IM
WHITE, DONALD C, PO BOX 1449,67337
251-1200
35 M 3515 65 R

COLBY—913
(Northwest Kansas Society)

DAHL, ASHER W, COLBY MED & SURG CTR,67701
462-3333
28 M 1902 58 FP
HASSETT, GERARD R, 1875 HARVEY,67701
-
24 M 3006 50 R
HILDYARD II, VICTOR H, COLBY MED & SURG CTR,67701
462-3332
47 M 702 73 FP
JACOBSEN, DWIGHT SKINNER, COLBY MED & SURG CTR,67701
462-3333
31 M 3545 60 GS
KOLSTE, REX J, COLBY MED & SURGICAL CTR,67701
462-3332
53 M
REGIER, LADONNA M, COLBY MED SURG CTR,67701
462-3332
47 F 1902 73 FP
SMITH JR, FLOYD L, 880 SUNSET,67701
-
20 M 1902 44 OO

COLDWATER—316
(Iroquois County Society)

GOERING, DONALD O, BOX 748,67029
582-2136
31 M 1902 56 FP
ANDREASEN, RAYMOND L, 114 W PINE,66725
429-3744
47 M 1720 74 FP
BELCHER, GEORGE D, BOX 309,66725
429-2557
34 M 1902 60 FP
JONES, FORREST H, 219 S KANSAS,66725
429-3744
25 M 1902 54 FP
PASIMIO, ROGER S, R2 BOX 259,66725
429-1977
38 M 74801 62 GS

COLLYER — 913
(Central Kansas Society)

BERNER, NEAL E, RR 1 BOX 10, 67631
743-2124
44 M 1902 72 FP

COLWICH—316
(Sedgwick County Society)

LIES, BARTHEL N, 309 S THIRD,67030
-
11 M 2802 37 OO

CONCORDIA—913
(Cloud County Society)

BRAY, AVIS PAGE, 1010 3RD AVE,66901
243-1560
17 F 702 54 FP
BUTT, MUHAMMAD, 1010 THIRD AVE,66901
243-1560
46 M 70401 69 GS
CORNELL, EARL G, 1010 THIRD AVE,66901
243-1560
54 M 1902 79 FP
FOWLER, WAYNE L, 1010 THIRD,66901
243-1560
23 M 1720 47 IM
GELVIN, E RAYMOND, 831 WEST NINTH,66901
243-1560
03 M 3005 27 GS
GRANT, MICHAEL O, 1010 THIRD,66901
243-1560
46 M 1902 79 FP
HOFER, DEWAYNE O, COUNTRY CLUB DR,66901
243-1263
36 M 1606 62 R
KOSAR, CLARENCE D, BOX 362,66901
-
98 M 1902 26 OO
KUEKER, RICHARD J, 524 PECK,66901
-
53 M 1901 79 OR
LAWTON, MARVIN K, 1010 THIRD,66901
243-1560
31 M 3005 58 GS
LLOYD, JAMES W, 910 WEST 11TH,66901
243-7011
44 M 1902 73 FP
MOORE, JAMES E, PO BOX 305,66901
243-7636
48 M 1902 74 P
NELSON, PAUL L, 1010 THIRD AVE,66901
243-1560
27 M 1902 55 PO
NEWMAN, CARL T, PO BOX 587,66901
243-2511
49 M 64914 76 U
OWENSBY, L C, 222 W SIXTH,66901
243-3386
21 M 2802 44 OPH
RUZICKA, LAWRENCE J, 1115 HILLSIDE DR,66901
243-1560
13 M 3005 40 ANES
SAUNDERS, MICHAEL E, 10 LOST CREEK LANE,66901
243-1560
50 M 1902 73 IM
STRYKER JR, HENRY B, 717 FIRST AVE,66901
-
19 M 3501 44 OO
THORNTON JR, FOXHALL P, 723 W 7TH ST,66901
243-1560
25 M 5101 50 IM
WOLF, PATRICK G, 1413 COUNTRY CLUB DR,66901
243-1560
52 M 1902 77 IM

COTTONWOOD FALLS—316
(Flint Hills Society)

BROWNING, JIMMIE L, BOX 486,66845
273-6753
50 M 1902 78 FP
MCKEE, LEO F, ,66845
273-6681
16 M 1902 39 FP

COUNCIL GROVE—316
(Flint Hills Society)

ALLRED, CHARLES T, 221 HOCKADAY,66846
767-5126
53 M 1902 78 FP
BARKER, ROYAL A, 221 HOCKADAY,66846
767-5126
21 M 1902 53 FP
BLACKBURN, ROBERT W, 221 HOCKADAY,66846
767-5126
22 M 1902 49 FP

SCHULTZ, JAMES E, 221 HOCKADAY,66846
767-5126
26 M 1902 56 FP

CUNNINGHAM—316
(Ninnescah Society)

ALLBRITTEN JR, FRANK F, PO BOX 177,67035
-
14 M 4101 38 OO

DE SOTO—913
(Johnson County Society)

POMMERENKE, FORREST A, 206 E SECOND,66018
585-1177
48 M 1902 75 FP

DENTON—913
(Northeast Kansas Society)

YODER, EMERSON O, ,66017
359-6531
14 M 1902 49 FP

DERBY—316
(Sedgwick County Society)

MCKERRACHER, ROBERT O, 400 A NORTH BALTIMORE,67037
788-1779
27 M 3901 55 FP

MOYER, HERMAN J, 200 S BALTIMORE,67037
788-1484
24 M 3901 55 FP
NIEDEREE, DAVID W, 1410 N WOODLAWN,67037
-
56 M 3006 82 FP
VINZANT, MARK N, 1410 N WOODLAWN,67037
681-3092
45 M 64914 75 FP

DIGHTON—316
(Southwest Kansas Society)

VON LEONROD JR, GEORGE, PO BOX 146,67839
397-5314
16 M 1902 43 FP

DODGE CITY—316
(Ford County Society)

AMAWI, MOHAMMAD S, DODGE CITY MED CENTER,67801
225-1371
46 M 87501 71 GS
AVILA, OSCAR A, DODGE CITY MED CENTER,67801
225-1371
41 M 17603 69 IM
AYUTHIA, ISSARA I, 2004 FREDERICK DR,67801
-
40 M 89101 66 PATH
BOLES, R DALE, DODGE CITY MED CENTER,67801
225-1371
23 M 3901 53 PD
BROWNRIGG, RICHARD L, 108 ROSS BLVD,67801
225-0075
35 M 1902 61 U
BUSCH, ANTHONY B, SOUTHWEST CLINIC,67801
-
05 M 2002 31 FP
CHOTIMONGKOL, ANUPONG, DODGE CITY MED CENTER,67801
225-1371
43 M 89102 69 OBG
CONARD, CLAIR C, DODGE CITY MED CENTER,67801
225-1371
27 M 1902 55 IM
GARCIA, GUILLERMO O, 1206 FRONTVIEW,67801
225-7710
43 M 23101 68 ORS

JAMBOR, CHRISTOPHER N, DODGE CITY MED CENTER,67801
225-1371
51 M 1902 78 PD
JOHNSON, HOWELL D, DODGE CITY MED CENTER,67801
225-1371
45 M 1902 71 IM
KYI, WIN M, SOUTHWEST CLINIC,67801
-
49
MCCOY, RONALD, SOUTHWEST CLINIC,67801
227-3141
19 M 3901 47 FP
MCELHINNEY, CHARLES F, DODGE CITY MED CENTER,67801
225-1371
36 M 1902 62 GS
MCGINNIS, MICHAEL J, 2010 1ST AVE,67801
227-3141
41 M 5501 69 GS
NIXON, JAMES E, PO BOX 1318,67801
225-1033
40 M 4812 72 OR
OHMAN, RICHARD J, 1810 1/2 FAIRWAY DR,67801
-
15 M 2407 41 OO
PIZARRO, FE E, 806 SECOND,67801
227-3141
44 F 74810 68 PD
REDDY, SATTI S, 108 RUSS BLVD,67801
225-0075
35 M 49504 66 U
SCHWARTZ, EUGENE W, 1ST NATL BANK BLDG,67801
225-4261
24 M 1902 50 OPH
STOCKWELL, MORGAN U, 1304 GRAY,67801
225-1371
24 M 1902 55 IM
TREKELL, WILLIAM V, SOUTHWEST CLINIC,67801
227-3141
25 M 1902 52 ORS
TROTTER, ROGER COURTNEY, 1111 SIXTH AVE,67801
225-6120
47 M 1902 74 FP
VIERTHALER, CARL A, DODGE CITY MED CENTER,67801
225-1371
53 M 1902 78 IM
WIN, AYE M, SOUTHWEST CLINIC,67801
-
227-3141
50
ZACHARIAS, CARL KURT, DODGE CITY MED CENTER,67801
225-1371
21 M 40707 47 ORS

EL DORADO—316
(Butler-Greenwood Society)

BRIAN, ROBERT M, 123 N ATCHISON,67042
321-1230
02 M 1606 30 FP
DELLETT, KENNETH B, 3RD & VINE,67042
321-1910
30 M 1902 55 OPH
GIROD, CHARLES I, 526 N WASHINGTON,67042
321-4981
11 M 4706 44 GS
HAFFNER, WILLIAM N, 123 N ATCHISON,67042
321-5630
35 M 1902 61 GS
JACOB, KANNAMPALLY L, 123 N ATCHISON,67042
321-0056
31 M 49537 59 U
KASSEBAUM, GLEN E, RR #2 BOX 19,67042
-
98 M 1606 23 OO
LEE, YONG U, 123 N ATCHISON,67042
321-5630
35 M 58310 60 GS
MARSHALL, ROGER W, 421 N ARTHUR,67042
-
60 M 1902 87
OLSEN, PHILLIP S, 123 N ATCHISON,67042
321-2100
46 M 1902 73 IM
OVERHOLSER, NORMAN H, 119 N JONES,67042
321-2010
16 M 1902 41 FP
PATRON, RICARDO A, 123 N ATCHISON,67045
321-7596
31 M 74808 52 OBG

REDDY, VENUMBAKA C, RDDM 302,67042
321-3300
46 M 49511 70 IM
SHIELDS JR, JAMES M, 119 N JDNES,67042
321-2010
18 M 4802 42 FP
SIWEK, CHRISTOPHER W, 123 N ATCHISDN,67042
321-5211
48 M 75911 71 DRS
WHITE II, BENJAMIN E, 119 N JDNES,67042
321-2010
27 M 1902 54 FP

ELKHART—316
(Seward County Society)

CABRERA, ALBERTO, BOX 997,67950
697-2155
30 M 74801 55 GS
CABRERA, NATIVIDAD R, 411 SUNSET DR, 67950
697-2153
31 F 74801 56 OBG
IWAY, BELIND D, 411 SUNSET BDX 878,67950
697-2175
42 M 74811 66 IM
IWAY, DLIVIA N, PD BDX 878,67950
697-2175
43 F 74811 68 P
PERIDD, DOMINADOR T, BDX 997,67950
697-2155
44 M 74801 68 GS

ELLINWOOD—316
(Barton County Society)

LAW, FINOLEY, PD BDX 668,67526
564-2170
22 M 1902 51 FP

ELLIS—913
(Central Kansas Society)

RDCHANAYDN, PIRA, 1204 WASHINGTON,67637
726-4956
43 M 89101 69 FP
SURFACE, GARDNER A, 101 WEST 13TH,67637
726-4454
02 M 1902 29 DD

ELLSWORTH—913
(Central Kansas Society)

DAVIS, GEDRGE R, 308 KINGSLEY,67439
472-3121
19 M 1902 44 GS
D'DDNNELL, HAROLD F, 412 BLAKE,67439
-
99 M 1902 26 DD
SEITZ JR, JDSEPH E, 308 KINGSLEY,67439
472-3121
22 M 1902 46 FP

EMPORIA—316
(Flint Hills Society)

AMEND, DOUGLAS J, 827 CDMMERCIAL,66801
343-6565
46 M 1902 79 DBG
BARNETT, JAMES A, 919 W 12TH,66801
342-2521
54 M 1902 79 IM
BDSILJEVAC JR, JOSEPH E, 2522 W 15TH,66801
343-7043
51 M 1902 75 TS
BRADLEY, H RUSSELL, 1601 STATE,66801
343-2900
35 M 1902 61 FP
BROCKHOUSE, JDHN P, 1601 STATE,66801
343-2900
31 M 1902 57 1M
BURGESON, FRANK G, 1601 STATE,66801
342-6989
40 M 3005 65 OPH
BUTCHER, THOMAS P, 1128 LAWRENCE,66801
342-0722
05 M 1601 34 GS
CAMPBELL, EDWARD G, 1601 STATE,66801
343-2900
31 M 1902 61 FP
COLDSMITH, DONALD C, 1024 W 12TH, 66801
342-7047
26 M 1902 58 FP
DAVIS, DAVID R, 1025 STATE ST APT #2,66801
-
02 M 2101 28 DD
DICK JR, HENRY J, 25 WEST FIFTH,66801
431-9310
27 M 1902 58 FP
EDWARDS, DAVID J, 1601 STATE ST,66801
343-1191
43 M 2803 69 DRS
ELLIS, BDBBY J, 1601 STATE,66801
343-2900
51 M 1902 77 1M
FARRIS, RONNIE S, 1601 STATE,66801
343-2900
50 M 3840 75 GS
GANN, E LAMONTE, RR #2,66801
-
07 M 2802 37 DD
GARCIA, GOULD C, 919 WEST 12TH AVE,66801
342-2521
32 M 3607 58 IM
GEITZ, JAMES M, 919 W 12TH,66801
342-2521
46 M 1902 72 IM
GINAVAN, DUANE A, 1024 W 12TH,66801
342-5876
35 M 1902 62 FP
GLENN, JAMES N, 1601 STATE,66801
343-7650
40 M 4804 66 DRS
HARVEY, JDHN E, 2506 W 15TH,66801
343-2900
39 M 1902 65 DBG
HAVENHILL II, MARSHALL A, 812 ANDERSDN ST,66801
343-6400
35 M 1902 61 DBG
HDPPER, CHARLES R, 1726 DLD MANOR RD,66801
-
17 M 1902 47 DD
HOWELL, BARBARA JOYCE, 2510 W 15TH,66801
343-7590
45 F 3401 78 PD
KELLING, CDLLYER, 1614 E WILMAN,66801
343-7676
50 M 1902 75 R
KNECHT, STEPHEN M, 12TH & CHESTNUT,66801
342-7722
44 M 1902 70 R
KRETSINGER DD, W BROCK, 919 WEST 12TH,66801
342-2521
48 M 2878 77 1M
MIGUELIND, DLIVER M, 12TH & CHESTNUT,66801
343-6800
35 M 74801 57 PATH
MDRGAN, JOHN L, 1710 YUCCA LANE,66801
-
15 M 4101 40 DD
NEIGHBDR, RALPH M, 827 COMMERCIAL ST,66801
343-6565
46 M 1902 72 DBG
NEUER, FREDERICK S, 12TH & CHESTNUT,66801
342-7722
46 M 3601 71 R
PASTDR, VICTDR HUGD, 1601 STATE,66801
342-7715
43 M 13202 68 U
PIERSDN, MARK E, 1024 W 12TH,66801
343-6864
50 M 1902 80 FP
SCHELLINGER, RICHARD P, 1128 LAWRENCE,66801
342-0722
22 M 3005 49 GS
SNOWBARGER, MARVIN D, 1601 STATE STREET,66801
343-2900
29 M 1902 55 FP
SPEARS, CHESTER A, 12TH & CHESTNUT,66801
343-6800
50 M 2834 76 PATH
TRIMBLE SR, DAVID P, 1703 SHERWDDDWAY,66801
342-2572
04 M 1902 32 DPH
UNDERWDDD, CHARLES C, 25 WEST 5TH,66801
342-2341
07 M 1902 32 1M
VANDER VELDE, STANLEY L, 1527 BERKELEY RDAD,66801
-
16 M 1902 43 DD

WRIGHT, KENDALL M, 1024 WEST 12TH,66801
343-2376
45 M 1902 71 FP

ERIE—316
(Southeast Kansas Society)

BRYAN, EMERY C, RT 2 BOX 171,66733
-
04 M 1902 32 00
HANOSHY, STANLEY E, PO BOX 256,66733
244-3291
54 M 1902 79 FP

ESKRIDGE—913
(Flint Hills Society)

WALKER, WILLIAM H, 2ND & CEDAR,66423
-
10 M 2401 38 IM

EUDORA—913
(Douglas County Society)

HOLLADAY, KENNETH R, PO BOX G,66025
542-2345
34 M 1902 58 FP

EUREKA—316
(Butler-Greenwood Society)

CISKEY, WILLIAM J, PO BOX 310,67045
583-7401
47 M 1902 72 FP
SKAER, STANLEY ALLEN, 100 E 16TH,67045
583-7486
40 M 3901 65 GS

FALL RIVER—316
(Sedgwick County Society)

CARTER, MACK A, RR 1 #9,67047
-
18 M 1902 50 00

FORT SCOTT—316
(Bourbon County Society)

AKERS, GUY I, 710 W 8TH,66701
223-3100
20 M 1902 53 FP
ALOIS, HENRY, 710 W 8TH,66701
223-3100
13 M 1902 41 OBG
ALOIS, WILLIAM, 710 WEST 8TH,66701
223-3100
20 M 1902 44 GS
BASHAM, JAMES J, 702 MEADOW LANE,66701
-
14 M 1902 37 00
BENAGE, JOHN F, 821 BURKE,66701
223-2200
32 M 1902 58 OBG
BRAUN, EDWARD W, 710 WEST 8TH,66701
223-3100
42 M 1902 68 U
BURKE, JAMES J, 710 W 8TH,66701
223-3100
35 M 2834 61 IM
CHOW, STANLEY Y, 1410 S EDDY,66701
223-2200
18 M 24222 39 R
DUNSHEE, CARLYLE M, 710 W 8TH,66701
223-3100
32 M 1902 57 GS
GETTLER, DEAN T, 710 WEST 8TH,66701
223-3100
31 M 1902 57 GS
GOOD, JAMES T, 821 BURKE,66701
223-2200
21 M 2802 45 PATH
GRANTHAM, HERBERT G, 701 W EIGHTH,66701
223-2200
49 M 4501 76 PATH
GRIMALDI, GARY A, 710 W EIGHTH,66701
223-3100
49 M 1902 74 OBG
IRBY, ADDISON C, 416 S JUDSON,66701
-
05 M 1606 2B 00
IRBY, PRATT, 124 S CRAWFORD,66701
-
13 M 4705 36 00
KERR, GERALD F, RR 5,66701
-
44 M 1902 B4 PATH
MCCANN, PATRICK E, 710 WEST 8TH,66701
223-3100
28 M 1902 59 IM
MCKENNA, MICHAEL J, 323 S JUDSON SUITE 120,66701
223-3950
38 M 1902 64 FP
NELSON, T EUGENE, 710 W 8TH,66701
223-3100
41 M 1902 69 FP
NICHOLS, ROBERT R, 102 S JUDSON,66701
223-4100
50 M 2803 76 FM
PHELPS, DAVID WAYNE, 102 S JUDSON,66701
223-4100
51 M 1902 76 FP
RADOM, SANFORD B, RT 1 BOX 205B,66701
223-6029
40 M 1642 66 R
REEVES, CHARLES S, 710 W 8TH,66701
223-3100
37 M 1902 63 IM
SPENCER, JOHN HAROLD, 710 W 8TH,66701
223-3100
47 M 1902 74 FP
THORNTON, JAMES L, 710 W EIGHTH,66701
223-3100
55 M 1902 B0 PO
WALCH, J JAMES, 612 S NATIONAL, 66701
223-3041
37 M 1902 74 FP
WEDDLE, DOUGLAS P, 710 WEST 8TH,66701
223-3100
43 M 1720 69 FP

FREDONIA—316
(Southeast Kansas Society)

BACANI, OSWALDO, PO BOX 576,66736
378-3700
44 M 74B10 70 GS
BAYLES, HUGH G, PO BOX 30,66736
378-3412
25 M 1902 52 FP
BEAL, RAYMOND J, 310 S 15TH,66736
-
12 M 1902 3B 00
RINOT, PHILLIP L, 432 N SEVENTH,66736
378-229B
45 M 1902 71 FP
SUMNER, RALPH N, PO BOX 537,66736
378-2311
31 M 1902 57 FP

GARDEN CITY—316
(Southwest Kansas Society)

ARROYO, ZEFERINO, 2124 ANTLER RIDGE DR,67B46
275-3700
M 74B02 GS
AUSTIN, JOHN O, 601 N 6TH,67B46
276-2346
14 M 1601 40 FP
BEGGS, DAVID F, 603 N FIFTH,67846
275-3700
39 M 1902 64 IM
BIGLER, F CALVIN, 801 N FIFTH,67B46
275-2141
31 M B01 57 GS
BRUNO, JAMES W, 1133 KANSAS PLAZA,67846
276-8201
42 M 4706 66 FP

CALBECK, JOHN, 603 N FIFTH,67846
275-3700
50 M 1902 75 IM
COLLINS, SHARON A, 603 N FIFTH,67846
275-3700
51 F 2512 78 PO
OONNELLY, WM PATRICK, 2705 REBEL RO,67845
276-8201
M
EICHHORN, FRANK D, BOX 719,67846
276-8132
25 M 1902 56 FP
FENTON, ROBERT M, 603 N FIFTH,67846
275-3700
20 M 1902 54 FP
FRY, LUTHER _, ST CATHERINE HOSP,67846
275-7248
41 M 1902 67 OPH
GARDINER, TED M, 603 N FIFTH,67846
275-3700
48 M 506 74 PO
GILBERT II, JOHN H, 603 N FIFTH,67846
275-3700
46 M 1902 70 ORS
GREENWOOD, JAMES F, PO BOX 419,67846
275-3700
33 M 1611 65 FP
HANSEN, FRANK W, 603 N FIFTH,67846
275-3700
49 M 1902 76 PM
HUNSBERGER, TERRY R, O.D., 602 N THIRD,67846
275-7128
47 M 2878 73 FP
JACKSON, MICHAEL O, 603 N FIFTH,67846
275-3700
51 M 4814 76 FP
KALBAC, RICHARD W, 603 N FIFTH,67846
275-3700
45 M 2803 70 OBG
KOKSAL, TOM, PLAZA MED CENTER,67846
276-8201
M 1902 76 FP
LE, CHUONG DUC, 711 N FIFTH,67846
275-4486
48 M 94101 73 GP
MATTHEWS, GEORGE E, D.O., 603 N FIFTH,67846
275-3780
M
MELIN, BRUCE D, 608 N FIFTH,67846
275-6111
51 M 5605 77 PATH
MEYERS, STEPHEN, 603 N FIFTH,67846
275-3700
48 M 2834 70 PD
MILLER, ROBERT E, 603 N FIFTH,67846
275-3700
26 M 4812 55 GS
MITCHELL, ROBERT H, 603 N FIFTH,67846
275-3700
M ORS
MORTON, JOHN E, 1505 E SPRUCE,67846
-
99 M 35211 26 OO
RODRIGUEZ, PAUL L, BOX 1729,67846
275-6111
39 M 4706 66 R
SPIKES, MARION E, 603 N 5TH,67846
275-9444
26 M 1902 62 FP
TEARE, MAX E, 1007 DAVIS,67846
276-7689
28 M 1902 54 P
TURNER, JOHN W, 806 E THOMPSON,67846
276-3292
13 M 1902 39 FP
VACHAL, EVA, 608 N FIFTH,67846
275-6111
F 1902 PATH
WILEY, HORACE M, BOX 1136,67846
276-6901
12 M 2802 40 GS
ZELLER, MYRON J, 603 N FIFTH,67846
275-3700
38 M 1902 64 OM

GARDEN PLAIN—316
(Sedgwick County Society)

LINO II, EDWARD J, 728 BIERMANN,67050
535-2218
53 M 1902 78 FP

REINHAROT-WOLF, TAISSIA L, PO BOX 273,67050
-
19 F 91302 42 DO

GARDNER—913
(Johnson County Society)

NIKNIA, SEYED M, PO BOX 326,66030
884-8711
38 M 51701 67 GS
REECE, A THOMEN, PO BOX 326,66030
884-8711
37 M 1902 63 FP
WHITAKER, MARK A, 136 E MAIN,66030
884-7822
53 M 1902 77 PO

GARNETT—913
(Anderson County Society)

DOUGHERTY, THOMAS M, 117 W 6TH,66032
448-5421
28 M 1902 55 FP
HARRIS JR, CLAIB B, 320 S OAK ST,66032
448-5431
17 M 1902 44 FP
HENDERSON, DAVID V, 117 W SIXTH,66032
448-5421
48 M 1902 79 FP
LEITCH, DAVID A, GARNETT MEDICAL CENTER,66032
448-5421
38 M 1902 63 FP
STEVENS, MILOREO J, 202 W 4TH,66032
448-5454
23 F 1902 47 FP
STEVENS, ROBERT L, 202 WEST 4TH,66032
448-5454
23 M 1902 47 FP

GIRARD—316
(Crawford County Society)

FRIGGERI, ROBERT W, 111 N SUMMIT,66743
724-8723
23 M 1902 51 FP
HALL, WESLEY H, PO BOX 158,66743
724-6154
25 M 1902 57 FP
WILKINS, JAMES T, BOX 158,66743
724-6154
51 M FP

GLASCO—913
(Cloud County Society)

HARWOOD, CLAUDE J, PO BOX 428,67445
568-2245
25 M 1902 55 FP

GOESSEL—316

SCHMIDT, KENLEY O, PO BOX 126,67053
-
55 M 1902 85

GOODLAND—913
(Northwest Kansas Society)

AUSTIN, KENNETH O, 520 MAIN,67735
899-5651
33 M 3005 63 FP
LONG, LLOYD J, 520 MAIN,67735
899-5651
37 M 1720 63 FP
MCCULLOUGH, ROBERT C, 520 MAIN PO BOX 180,67735
899-5651
25 M 702 58 GP
MITRA, SUDHEER, 1206 MAIN,67735
899-5976
F GS
OLSON, CLITUS W, 520 MAIN ST,67735
899-5651
16 M 3005 48 GS

GREAT BEND—316
(Barton County Society)

ALDERSON, THOMAS W. 3520 LAKIN,67530
792-5341
50 M 1902 75 FP
ARRIGHI, DAVID. 3520 LAKIN,67530
792-1227
51 M 1902 78 GS
BEAHM, ANOL W. 3923 BROADWAY,67530
793-7827
16 M 1902 43 FP
BEAHM, DONALD E. MED ARTS BLDG,67530
792-3626
45 M 1902 71 OPH
CAVANAUGH, CLAIR J. C K M C,67530
792-2617
23 M 1803 47 R
DEGNER, JAMES B. 3515 BROADWAY,67530
792-2617
31 M 1902 57 R
EVANS, WILLIAM R. 1912 LINCOLN,67530
-
25 M 1902 53 OO
FIESER, CARL W. 3515 BROADWAY,67530
792-2617
45 M 1902 71 R
FLESKE, LEONARD T. 1514 K 96 HWY,67530
792-4383
49 M 1902 75 ORS
GATENO, JOSEPH. 1031 JACKSON,67530
793-8429
25 M 64901 50 OBG
HILL, LARY MICHAEL. 1017 A JACKSON,67530
793-8141
51 M 1902 77 FP
HOLT, JOHN M. PO BOX 1328,67530
793-8429
35 M 1902 61 IM
JONES, EDWARD L. 3515 BROADWAY,67530
792-2511
35 M 1902 61 PATH
KING, WILLIAM T. 3421 FOREST,67530
793-3501
35 M 1902 61 OBG
KIRBY, MERLIN G. 3520 LAKIN,67530
792-1227
31 M 1902 56 GS
KRUEGER, HAVEN C. 1023 JACKSON SQUARE,67530
792-2163
32 M 1902 61 PO
MCALLASTER, WENDALE E. 2111 FOREST,67530
793-3591
24 M 1902 54 GS
NIEDEREE, W CURTIS. 3520 LAKIN,67530
793-3091
30 M 3006 56 GS
PECK, ROGER. PO BOX 1328,67530
793-8429
54 M 1902 81 IM
POLSON, ROBERT C. BOX A 1422 POLK ST,67530
793-8414
17 M 1902 42 OPH
PRESTON, RICHARD. PO BOX 1328,67530
793-8426
42 M 1902 69 IM
REPLOGLE, CHARLES B. 2111 FOREST,67530
793-3591
27 M 1902 53 FP
RUIZ, CARLOS M. PO BOX 1348,67530
792-3210
25 M 27501 52 P
SAYLER, JEROME. CENTRAL KS MEDICAL CENTER,67530
792-2511
20 M 4113 50 PATH
SCHUETZ, PERRY N. 1422 POLK BOX A,67530
793-8414
45 M 1902 71 OPH
SCHUKMAN, JAY S. 3520 LAKIN,67530
792-5341
50 M 1902 75 FP
SHIVEL, DAVID G. 3523 FOREST,67530
793-3523
28 M 1902 55 FP
SMITH, PERRY MILTON. 3520 LAKIN,67530
792-5341
52 M 1902 77 FP
SWAN, MAJOR MARTIN. 2520 MCBRIDE PKWY,67530
792-4540
06 M 1902 43 IM
UNREIN, ROBERT J. 1017A JACKSON,67530
792-2504
29 M 1902 58 FP
WHEELER, JAMES A. 3712 LAKIN,67530
384-5599
55 M 1902 88
WHITE, CHARLES L. 2412 OOVE TERRACE,67530
-
06 M 1902 36 OO
WIGGS, JAMES W. 1027 JACKSON,67530
792-1336
36 M 1720 63 N
WIKOFF, DONA_D _. 3520 LAKIN SUITE 108,67530
792-7353
49 M 3005 75 U
YOUN, HWAN. 3515 BROADWAY,67530
792-2617
48 M 58310 73 DR
ZURITA, MARCOS. PO BOX 1241,67530
793-3422
46 M 31901 69 ANES

GREENSBURG—316
(Iroquois County Society)

BRADLEY, J RODERICK. BRADLEY-WALDORF CLINIC,67054
723-2127
23 M 1902 47 FP
CANNATA, GENE. BRADLEY & WALDORF CLINIC,67054
723-2127
54 M 1902 79 FP
WALDORF JR, MELVIN H. BRADLEY-WALDORF CLINIC,67054
723-2127
23 M 1902 47 FP

HALSTEAD—316
(Harvey County Society)

AILLON, ALEJANDRO J. HERTZLER CLINIC,67056
835-2241
39 M 26402 63 TS
BAILEY, COLIN. HERTZLER CLINIC,67056
835-2241
33 M 35205 59 GYN
BEUGELSDIJK, HENRY PETER. 421 SPRUCE,67056
835-2241
49 M 1902 74 ANES
BOUDREAUX, VELTIN J. PO BOX 53,67056
835-2241
37 M 4812 64 R
BURNETT, A DEAN. HERTZLER CLINIC,67056
835-2241
21 M 1902 52 GS
DECKER, DONALD D. HERTZLER CLINIC,67056
835-2241
31 M 1902 56 CD
EASTES, GARY DEAN. HERTZLER CLINIC,67056
835-2241
44 M 4812 71 U
GNAU, FREDRIC B. 803 MAIN,67056
835-2241
42 M 1902 68 OTO
HAIRE, WILLIAM D. 901 MAIN,67056
835-2241
49 M 1902 74 HEM
HARMS, WILMER A. THE HERTZLER CLINIC,67056
835-2241
22 M 1902 56 OPH
HOOFER, WILFORD O. HERTZLER CLINIC,67056
835-2241
30 M 1902 55 TS
KIMMEL, KENNETH K. 4TH & CHESTNUT,67056
835-2241
52 M 1902 77 IM
MALONE, EUGENE M. HERTZLER CLINIC,67056
835-2241
23 M 1902 56 IM
MARSH, CONNIE M. HERTZLER CLINIC,67056
835-2241
47 F 1902 75 IM
RIZZA, ROBERT G. RT #2,67056
-
30 M 1201 56 PD
SHAH, SHARFUODIN. HERTZLER CLINIC,67056
835-2241
31 M 70401 58 IM
STOFFER, ROBERT P. HERTZLER CLINIC,67056
835-2241
26 M 1902 48 IM

TEJAND, NEDNILD A, HERTZLER CLINIC,67056
835-2241
43 M 74808 67 ORS
WELCH, JACK W, HERTZLER CLINIC,67056
18 M 1902 51 DD
WILSON, H RANDOLPH, HERTZLER CLINIC,67056
835-2241
20 M 4112 45 GYN

HANOVER—913
(Northeast Kansas Society)

WARREN, LINDA D, BOX 38,66945
325-2240
44 F 1902 70 FP
WARREN, ROGER D, BOX 38,66945
337-2214
31 M 1902 57 GS

HARPER—316
(Tri-County Society)

GARDNER, BILLIE L, 121 E MAIN,67058
896-3661
25 M 1902 57 FP

HAYS—913
(Central Kansas Society)

ALBERS, ROBERT C, 2501 E 13TH SUITE 10,67601
625-4224
48 M IM
APPLEGATE JR, FRANCIS R, 1010 DOWNING,67601
628-8218
30 M 1902 55 DPH
BULA, RALPH E, 3209A WILLOW,67601
12 M 1902 37 OO
CARLSON, EARL V, DRAWER 430,67601
628-8221
31 M 3005 56 DRS
CECIL III, JOHN, BOX 833,67601
625-6521
43 M 4804 69 R
CODY, DOROTHY, 2704 WOODROW CT,67601
628-4000
29 F 3607 53 P
CODY, JOHN, 2704 WOODROW CT,67601
628-2871
25 M 401 60 P
COX, ROBERT H, 2507 CANTERBURY RD,67601
628-3051
43 M 1902 70 PD
CRAMM, RUSSELL E, 105 W 13TH,67601
625-8269
30 M 1902 56 GS
DORSCH, JOHN N, 306 W 38TH,67601
628-6151
54 M 1902 79 FP
DYCK, ERIC LEE, FAMILY PRACTICE CLINIC,67601
628-6151
52 M 1902 77 FP
EDDY, VICTOR M, 105 W 13TH,67601
625-2551
29 M 1902 55 GS
HAIGLER, JAMES P, 217 W 24TH,67601
625-2855
13 M 3006 39 DD
HALLING, L WILLIAM, 1300 EAST 13TH,67601
625-5646
27 M 5002 57 PATH
HUTCHISON, GLEN C, 3200 COUNTRY LANE,67601
628-8251
21 M 1902 50 ANES
HUTCHISON, MARC K, 213 CASTILLIAN GARDENS,67601
628-6760
M ANES
KANE JR, WILLIAM M, CANTERBURYS CLINIC PA,67601
628-3245
27 M 1001 54 DBG

KELLY, A CHRISTINE, 2501 E 13TH SUITE 7,67601
528-3217
49 F 2846 77 GS
KIFER, C JAMES, BOX 833,67601
625-6521
45 M 1902 71 DR
LASLEY, MICHAEL B, 2501 EAST 13 STE 7,67501
628-3217
45 M 1902 71 GS
LOEB, ELSIE L, 2501 E 13TH SUITE 10,67601
625-4224
51 M 1902 78 IM
MATTICK, IRVIN H, 2818 N VINE,67601
528-8221
18 M 2802 43 DRS
MCDONALD, KEVIN R, PO BOX 1176,67601
628-6014
52 M 3006 78 U
MYRICK, MICKEY, 2501 CANTERBURY RD, 67601
628-6151
42 M 3005 74 FP
NEIL, ROY NEWTON, 1108 MAIN ST S 2018,67601
628-3215
38 M 3005 65 PATH
NEWCOMB, WARD M, 1300 E 13TH,67601
625-5646
37 M 3005 71 PATH
RAJEWSKI, RICHARD L, 2509 CANTERBURY,67601
628-6151
51 M 1902 76 FP
REYNOLDS, JEFFREY C, 2517 CANTERBURY RD,67601
625-7311
39 M 1902 64 ENT
RICHARDS, DALLAS LEE, 2501 E 13TH SUITE 10,67601
625-4224
49 M 1902 76 IM
RUTNGAMLUG, LUECHA, 105 W 13TH,67601
628-6175
40 M 89101 68 GS
SILER, EUGENE T, 1010 DOWNING,67601
628-8218
24 M 1902 52 DPH
STADALMAN, ROSS EUGENE, 2501 E 13TH STE 7,67601
628-3217
47 M 1902 73 GS
STUMP, HARL G, 105 W 13TH,67601
625-2551
39 M 1902 65 GS
WATTS, HARRY E, 1010 DOWNING AVE,67601
628-8218
27 M 702 54 OPH
WEBER, WALLACE V, 2707 VINE SUITE 10,67601
628-3231
43 M 1902 69 D
WERTH, DARREL D, PO BOX 1176,67601
628-6014
50 M 1902 75 U
WIEGMAN, HUGH ALAN, BOX 833,67601
625-6521
34 M 1803 60 R
WILCOX JR, HOWARD L, PO DRAWER 430,67601
628-8221
44 M 1902 70 DRS

HAYSVILLE—316
(Sedgwick County Society)

MORGAN, NOVA L, 301 W GRAND,67060
524-3275
20 M 3901 50 FP
SAYEED, BASEER A, 138 STEWART,67060
529-0450
49 M 49504 74 IM

HERINGTON—913
(Dickinson County Society)

BUSTOS, JONAS G, 1005 NORTH 8,67449
258-3705
41 M 74810 68 GS
DOZIER, FRED S, 1005 NORTH 8 STREET,67449
258-2215
10 M 4804 34 FP

HESSTON—316
(Harvey County Society)

DIENER, CLAYTON H, PO BOX 386,67062
327-4122
18 M 1902 54 GS
FRIESEN, FLORENCE V, SHOWALTER VILLA,67062
87 F 1611 14 00
HENSON, STEVEN R, 608 RANDOM RD,67062
327-4174
61 M 1902 87
YODER, VERNON E, ROUTE #1,67062
283-2400
31 M 4802 61 P

HIAWATHA—913
(Northeast Kansas Society)

OUCKETT, THOMAS G, 201 MIAMI,66434
10 M 1902 34 00
HALL JR, ERNEST B, 202 S SIXTH,66434
742-7814
53 M 1902 78 FP
LARSON, GELBERT L, 314 OREGON,66434
742-2161
30 M 1803 64 FP
MEIDINGER, RAY, 111 S FOURTH,66434
742-2135
03 M 3005 32 FP
SINNING, GARY, 314 OREGON,66434
742-2161
49 M 1902 74 FP

HILL CITY—913
(Central Kansas Society)

REDDY, B N, 114 E WALNUT,67642
674-2191
38 M 49557 66 RT
REDDY, P JAGANNADHA, 80 WALNUT DRIVE,67642
674-2255
42 M 49511 66 GS

HILLSBORO—316
(Marion County Society)

ENS, GERHARD GEORGE, 613 SOUTH MAIN,67063
947-5931
20 M 1902 55 FP
ENS, PETER O, 209 S MAIN,67063
947-3671
14 M 1902 51 FP

HOISINGTON—316
(Barton County Society)

FERNANDEZ, HECTOR O, 351 W TENTH,67544
653-4944
41 M 74809 66 GS
FLANNER, FRANK R, 353 W TENTH,67544
653-4138
43 M 1902 79 FP
MOORE, ROBERT, 814 NORTH ELM,67544
553-2151
22 M 3901 53 FP

HOLTON—913
(Shawnee County Society)

MOSER, ERNEST C, 438 HILLCREST DR,66436
09 M 1902 34 00

HORTON—913
(Northeast Kansas Society)

FRANCISCO, EDGARDO, PO BOX 6,66439
486-2646
39 M 74802 57 GP
WALTON, PHILIP D, 1903 EUCLID,66439
486-2828
32 M 1902 63 FP

HOXIE—913
(Northwest Kansas Society)

NEUENSCHWANDER, JOHN, 1401 QUEEN,67740
675-3292
26 M 2802 51 FP
NEUENSCHWANDER, JOHN RAND, 700 MAIN,67740
675-3292
47 M 1902 72 FP

HUGOTON—316
(Seward County Society)

FREDERICK, M F, 1006 S JACKSON,67951
544-2784
20 M 1902 44 FP
WINGER, RAYMOND E, 1006 S JACKSON,67951
544-2424
51 M 1902 77 FP

HUMBOLDT—316
(Southeast Kansas Society)

LONG, EDWARD E, 8TH & NEW YORK,66748
473-2411
21 M 1902 50 FP

HUTCHINSON—316
(Reno County Society)

ADAMS JR, MARCUS W, 2101 N WALDRON,67501
663-6121
33 M 3901 59 PO
ALBRIGHT, JEROLD D, 2101 N WALDRON,67502
663-6121
39 M 1902 66 FP
BARKER, STANTON L, 2101 N WALDRON,67501
663-6121
54 M 1902 79 FP
BAUER, THOMAS A, 2101 N WALDRON,67502
663-6121
41 M 1902 67 IM
BLANK, JOHN N, ROUTE 5 BOX 220,67501
07 M 1902 38 00
BORRA, MARIO J, 1 WEST 8TH,67501
562-1751
24 M 2401 47 U
BOS, NORMAN C, 2101 N WALDRON,67502
663-6121
24 M 1611 47 ORS
BOUDA, DAVID W, 2101 WALDRON,67502
663-6121
45 M 1902 72 IM
BRADA, DONALD ROBERT, 308 W 20TH,67501
562-6041
39 M 1902 65 P
BRYANT, EUGENE A, 1701 E 23RD,67502
51 M 1902 75 PATH
BURGER, J DALE, 2101 N WALDRON,67502
663-6121
21 M 1902 46 FP
CASEY, JAMES, 2101 N WALDRON,67501
663-6121
42 M 3005 69 PO
CHERVEN, PHILIP L, 1100 N MAIN,67501
662-3364
45 M 2501 71 PO
COKER JR, GRADY N, 1100 N MAIN,67501
663-2151
25 M 1201 54 OBG
DAVIS, WILLIAM O, 1100 N MAIN,67502
663-2151
M 1902 70 FP
DEPENBUSCH, FRANCIS L, 1708 E 23RD,67501
663-7187
38 M 1902 65 OPH
DUHON, JOHN MARQUE, 1701 E 23RD,67502
665-2126
47 M 4802 75 DR

ECKART, DE MERLE E, 201 N MAIN #315A,67501
662-4921
14 M 1902 40 P
FALTER, RICHARD T, 1708 E 23RD ST,67501
663-7187
38 M 1902 67 OPH
FOSS, DANIEL C, 2101 N WALDRON,67501
663-6121
43 M 1902 69 GE
GARD, RICHARD A, 1100 N MAIN,67501
225-7710
51 M 1720 78 OBG
GRAVES, KATHRYN, 2101 N WALDRON,67502
663-6121
49 F 1902 74 O
HANSON, DAVID C, PO BOX 2737,67504
365-2131
46 M 512 73 FP
HEDRICK, KENNETH E, 2101 N WALDRON,67502
663-6121
27 M 1902 53 GS
HOLDERMAN, WALLACE D, 2101 N WALDRON,67501
663-4406
28 M 1902 54 ORS
HURWITZ, MICHAEL A, 2101 N WALDRON,67501
663-6121
50 M 2301 76 HEM
JARRETT, JOHN B, 1100 N MAIN,67501
663-2151
16 M 1902 40 DRS
JOHNSON, RANDLE C, 1100 N MAIN,67501
663-2151
M 1M
JOHNSON, RICHARD L, 2101 N WALDRON,67501
663-6121
M R
KEPKA, DENNIS J, 3117 S MEADOWLAKE DR,67501
663-2151
43 M 56101 77 FP
KLOSTERHOFF, BRUCE E, 720 N MAIN,67501
662-6041
45 M 1611 71 P
LESSER, DANE A, 2101 N WALDRON,67502
663-6121
49 M 3901 75 U
LETTNER, HANS T, BOX 159,67501
662-7801
23 M 40716 49 PATH
LUKENS, DAVID, 2101 N WALDRON,67502
563-1136
24 M 2307 48 IM
MARTINEZ, JOHN O, 1100 N MAIN,67501
663-2151
48 M 1902 74 IM
MCCOY, CHARLES T, 310 WOLCOTT BLDG,67501
662-0121
16 M 1902 41 DPH
MCMULLEN, JOSEPH E, 2101 N WALDRON,67502
663-6121
33 M 1902 62 GS
MULL, JOHN C, 2101 N WALDRON,67501
663-6121
34 M 1902 61 OBG
NEEL, WILBUR B, 2101 N WALDRON,67502
663-6121
24 M 1902 59 IM
NEUSCHAFER, DARREL R, 2101 N WALDRON,67501
663-6121
48 M 1902 74 OBG
NUNEMAKER, MARION E, PO BOX 1129,67501
562-5391
21 M 1902 46 ANES
OLMSTEAD, CALVIN G, 1100 N MAIN,67501
663-2151
50 M 6002 79 N
OMDAHL, NICHOLAS S, 2101 ND WALDRON,67502
663-6121
47 M 5605 74 IM
OPENSHAW, CALVIN R, 2020 N WALDRON,67502
662-0569
21 M 4901 44 GS
OYER, FREDERICK R, 2101 N WALDRON,67502
663-6121
43 M 1606 69 DR
PAINE, GEORGE E, 220 W 23RD,67502
-
94 M 1606 19 DD
PEASE, GARY L, 1712 E 23RD,67501
662-4458
41 M 3005 67 OTO
PERKINS, JACK L, 2101 N WALDRON,67502
663-6121
24 M 1902 53 FP

QURESHI, HUMAYUN, 1100 N MAIN,67501
663-2151
49 M 49548 75 IM
RATE, PEGGY S, 2221 E 56TH,67502
663-6121
46 F 1902 73 PD
RATE, ROBERT G, 2221 E 56TH,67502
663-6121
47 M 1902 74 IM
SCALES, WILLIAM M, PLAZA TOWERS,67501
-
00 M 1803 31 DD
SCHEEL, BRADLEY J, 1100 N MAIN,67501
663-2151
48 M 1902 74 IM
SCHROLL, JACK C, 2101 N WALDRON,67502
663-6121
24 M 1902 49 OBG
SHAW JR, JAMES W, PO BOX 1646,67502
662-7801
40 M 1902 65 PATH
SHEARS, ROBERT N, 1100 N MAIN,67501
662-3364
20 M 1902 44 PD
SHERVIN, ADEL, 1600 N LORRAINE #120,67501
662-1742
47 M 73
SIBAI, M ATEF, 1100 N MAIN,67501
663-2151
48 M 87501 72 GPVS
SMITH, THOMAS WILLIAM, 1712 E 23RD,67501
662-4458
43 M 1643 68 OTO
SPITZER, JEROME S, 1100 N MAIN,67501
663-2151
33 M 3005 59 FP
STAFFORD, ROBERT W, 2101 N WALDRON,67502
663-6121
43 M 2101 69 IM
STENSAAS, CARL O, 401 WOLCOTT BLDG,67501
663-9147
10 M 1902 38 O
STOUT, JAMES M, 2101 N WALDRON,67501
663-6121
29 M 1902 55 FP
TAYLOR, E J, 1100 N MAIN,67502
663-2151
34 M 1902 61 FP
TISDALE, TERRANCE C, HUTCHINSON CLINIC PA,67501
663-6121
36 M 6701 61 ORS
TWEITO, DAVID H, 1100 N MAIN,67501
662-3364
38 M 1803 64 PD
VON RUDEN, WILLIAM J, PO BOX 220,67504
662-3306
26 M 1611 52 GS
WEIDENSAUL, D N, 2101 N WALDRON,67502
563-6121
50 M 1902 75 IM
WILLIAMSON, JOHN, 1100 N MAIN,67501
669-0191
35 M 2501 60 ORS
WORTMAN, JACK A, 2101 N WALDRON,67502
663-6121
34 M 1902 62 IM

INDEPENDENCE—316
(Southeast Kansas Society)

ATWOOD, LARRY C, 800 W MYRTLE,67301
331-8610
54 M FP
BAIR, ALBERT E, PO BOX 925,67301
-
16 M 1902 44 DO
BARBERA, PORTER E, 800 WEST CHESTNUT,67301
331-4400
19 M 4707 46 FP
CHAPPUIE, WILLIAM G, 800 CHESTNUT WEST,67301
331-5440
24 M 1902 51 FP
EMPSON, CHARLES L, PO BOX 848,67301
331-6019
37 M 1902 68 FP
KNUTH, KENNETH L, 2900 TERRA VISTA,67301
331-2200
22 M 1902 50 R
MYERS JR, EARL B, BOX 548,67301
331-3420
32 M 2803 64 GS

PATE_. V C. PO 80X 883.67301
331-2725
50 M 49576 74 ORS
PHIPPS. RONNY G. PO 80X 843.67301
331-7901
54 M 512 80 FP
PRENTICE. WALTER 8. PO 80X 628.67301
331-8650
29 M 1643 56 OR
STACEY. KIMBALL. 209 N SIXTH.67301
331-6350
M IM
SUTTON. RO8ERT E. PO 80X 1003.67301
331-7700
46 M 1902 72 FP
TONG. ROLANOO M. PO 80X 425.67301
331-6573
49 M 74801 72 GS

IOLA—316
(Allen County Society)

COPENING. TELL 8. 80X 386.66749
365-2134
43 M 1902 69 FP
OETAR. GEORGE F. 826 E MAOISON.66749
-
28 M 1902 57 OO
OICK. WILLIS G. 80X 826.66749
-
13 M 512 41 OO
LENSKI JR. FRANCIS X. 206 S JEFFERSON.66749
365-3901
26 M 1606 49 FP
MYERS. W EUGENE. 80X 645.66749
365-3732
12 M 1902 46 FP
SCHMAUS. LYLE F. 1020 N JEFFERSON.66749
-
99 M 1803 26 OO
WOLFE. 8RIAN O. 305 N WASHINGTON.66749
365-2134
M FP

JEWELL—913
(Mitchell County Society)

PLOWMAN. CARL W. .66949
-
99 M 1606 26 OO

JUNCTION CITY—913
(Geary County Society)

8OLLMAN. CHARLES S. PO 80X 397.66441
762-4575
41 M 3901 66 GS
8RETHOUR. LESLIE J. 1106 ST MARYS RO.66441
238-4151
13 M 3006 39 FP
8UNKER JR. HER8ERT L. 1106 ST MARYS RO.66441
238-5131
20 M 1606 45 FP
COPELANO. GARY A. GEARY COMMUNITY HOSP.66441
762-2387
42 M 1902 68 R
CRAIG. THOMAS A. 1106 ST MARYS RD STE 102.66441
762-4255
53 M 1902 78 IM
KIM. SUCHA. 1705 8ELAIR OR.66441
-
61 F 1902 87
LA8HSETWAR. S A. MEDICAL ARTS 8LDG.66441
762-4147
39 F 49528 64 OBG
MACE. RONALD O. PO 80X 163.66441
762-4884
42 M 3901 74 FP
MINNICK. CHARLES V. 435 W CHESTNUT.66441
-
08 M 2105 35 FP
O'OONNELL. HARRY E. 703 WEST CHESTNUT.66441
-
14 M 4113 42 OO
PATEL. MAHENORA N. 1106 ST MARYS RO STE 206.66441
762-2327
48 M 35207 74 IM
SCOTT. ALEX. 507 WEST 6TH.66441
238-2518
23 M 5605 48 FP
WRIGHT. STANLEY E. 700 ROCKLEOGE OR.66441
762-4884
47 M 3901 74 FP

KANSAS CITY—913
(Wyandotte County Society)

A8OOU. NA8IH I. KU MEOICAL CENTER.66103
588-6586
34 M 33002 58 A
AOAMS. MARY E. 3828 800TH #6.66103
-
50 F 1902 88
AOKISSON. WAYNE O. 1100 COUNTY LINE BL 4 #35, 66103
-
61 M 1902 87
AHNEMANN. JANET L. 4464 FISHER.66103
-
57 F 1902 86
AHUJA. OEEPAK. 3732 CAM8RIOGE.66103
-
62 M 1902
ALOERMAN. LILLIAN C. 1928 W 36TH.66103
831-0491
53 F 1902 84
ALEXANOER. CHARLES E. TWO GATEWAY CENTER #917.66101
321-6670
43 M 401 70 OBG
ALEXANOER. CLYOE W. 1514 NORTH 5TH.66101
281-4380
96 M 4707 23 FP
ALGIE. WILLIAM H. 3100 MINNESOTA #101.66102
281-2929
02 M 1902 27 IM
ALIFANO. CONNIE L. 1100 COUNTY LINE BL 4 #35, 66103
-
59 F 1902
ALLEGRE. ANN. 1225 N 78TH.66112
788-7099
50 F 1902 77 IM
ALLEN. KEITH 8. 3901 800TH #9.66103
-
60 M 1902 86
ALLEN. TIMOTHY E. 9201 PARALLEL PKWY.66112
651-7195
49 M 1902 76 R
ALLEN JR. WILLIAM R. 9201 PARALLEL.66112
334-4110
46 M 1902 78 R
ALLEN SR. WILLIAM R. 9201 PARALLEL.66112
-
M
ALLEY. RO8YN R. 4323 CAM8RIOGE.66103
-
61 F 1902 87
AMARE. MAMMO. KU MEOICAL CENTER.66103
588-6077
36 M 60501 61 IM
ANTHONY. THOMAS. 3734 800TH APT 7.66103
-
59 M 1902 88
APPEL8AUM. JAMES S. 4140 800TH PL APT 7.66103
-
60 M 1902 86
ARAKAWA. KASUMI. KU MEO CENTER.66103
588-6670
26 M 57211 53 ANES
ARENAL. ANGELA C. 8ETHANY HOSPITAL.66102
281-8839
38 F 35204 60 ANES
ARNETT. GWENOOLYN R. KU MEO CTR OIAG RAO OEPT.66103
588-6800
54 F 1902 79 OR
ARONSON. RITA K. STUOENT UNION.66103
-
56 F 1902 87
ASH. LISA M. 3815 SPRINGFIELO APT 1C.66103
-
62 F 1902 88
ASHER. MARC A. K U MED CENTER.66103
588-6130
35 M 1902 62 ORS
BAKER. MICHAEL P. 2520 W 39TH APT 2C.66103
-
52 M 1902 88
BANKS. OONALO E. 3741 SPRINGFIELO.66103
-
59 M 1902 88

8ARE, JANE E, 3747 SPRINGFIELD,66103
-
61 F 1902 88
8ARN5, EDWARD L, 3915 BOOTH APT 12,66103
-
59 M 1902 88
8ARR, ROBIN R, 1919 FEDERAL,66103
-
55 F 1902 84
8A55 JR, LEWIS N, 1975 N 5TH,66101
321-2320
21 M 1902 45 PD
8ATNITZKY, SOLOMON, K U MED CENTER,66103
588-6835
40 M 83601 64 DR
8AUER, LAIRD A, 4171 CAMBRIDGE,66103
-
56 M 1902 86
8EACH, ROBERT L, 3909 BOOTH #2,66103
-
48 M 1902 86
8ECKER, LESLIE E, 600 NEBRASKA,66101
342-4010
23 M 1003 46 U
8EILMAN, GREG J, 3133 EATON ,66103
-
59 M 1902 86
8EJAR, JOSE M, 3838 RAINBOW BLVD APT 609,66103
588-6970
46 M 31901 74
8ELL, GREGORY A, 3702 CAMBRIDGE,66103
-
59 M 1902 86
8ENSON, KIRK T, KU MED CENTER,66103
588-6670
54 M 1902 79 ANES
BERGIN, JAMES J, BETHANY MED CENTER, 66102
281-8767
28 M 2407 54 IM
8ERRIDGE, DEBRA L, 2219 W 39TH #1W,66103
256-9684
60 F 1902 87
8ETTIN, BRYCE D, 1820 S 31ST,66106
-
60 M 1902 87
8ETTY, JANE M, 4312 ADAMS,66103
-
51 F 1902 87
8ICHLMEIER, FRANKLIN G, 155 S 18TH,66102
371-6800
33 M 1902 58 CDS
8IXLER II, THOMAS J, KU MED CTR CARDIOVAS SURG,66103
588-6107
47 M 1205 74 CDS
8LACK, DAVID L, 4448 FISHER,66103
-
58 M 1902 84
8LACKBURN, TIMOTHY L, 3932 ADAMS #22,66103
384-1646
60 M 1902 86
8LAKELY, KENT W, 3744 BOOTH APT 2,66103
722-3025
62 M 1902 88
8LOMQUIST, GLENDA L H, 2707 N 72 TERR,66109
-
56 F 1902 85
8OOENSTEINER, DAVID C, K U MED CENTER,66103
588-6077
51 M 1803 76 IM
8OLING, JAMES M, 4127 THOMPSON APT 5,66103
-
58 M 1902 84
8OLINGER, ROBERT E, KU MEDICAL CENTER,66103
588-6022
19 M 1902 43 ENT
8OSILEVAC, FRED N, 155 S 18TH,66102
-
16 M 1902 44 OPH
8OTTERON, KELLY N, 4200 BOOTH,66103
-
62 F 1902
8OYD, HAROLD D, 5015 ELMWOOD AVE,66106
-
53 M 1902 88
8RACKETT JR, CHARLES E, KU MED CENTER,66103
588-6117
20 M 3501 44 NS
BRADY, PETER A, 3602 RAINBOW #306, 66103
262-8103
59 M 1902 86
8RANIECKI, MARYLEE A, 4130 EATON,66103
-
59 F 1902 86
8RAUN, STEVEN D, 1717 S 31ST APT 8,66106
362-3404
61 M 1902 87
8RILLHART, MAXINE T, 1610 WASHINGTON BOULEVARD,66102
321-4800
15 F 1902 50 FP
8ROWN, ROBERT L, 3919 ADAMS,66103
-
60 M 1902 87
8U88, STEPHEN K, 155 S 18TH,66102
371-6802
48 M 1902 74 ORS
8URRESS, FRED J, 3902 BOOTH #8,66103
-
62 M 1902 88
8UTTERFIELD, MARI ANNE, KU MED CENTER,66103
588-6670
52 F 1902 77 ANES
8YERS, MARTHA S, 4601 ORVILLE,66102
596-1313
54 F 1902 79 FP
CALDERON, JAIME, 4631 ORVILLE SUITE 201,66102
287-5556
39 M 26401 66 CO
CALKINS, JOHN W, KU MED CENTER,66103
588-6236
51 M 1902 76 OBG
CAMERON, JULIE F, 3600 STATE LINE,66103
-
60 F 1902 88
CAMERON, WILLIAM J, KU MEDICAL CENTER,66103
588-6200
29 M 2501 54 OBG
CARLIN, JAMES WILLARD, KU MED CENTER,66103
588-6670
51 M 1902 76 ANES
CARPENTER, PAUL R, 155 S 18TH SUITE 105,66102
371-6800
24 M 1902 50 GS
CARTY, RUSSEL W, 3900 BOOTH SUITE 2,66103
-
53 M 1902
CASTEEN, JOHN A, 3909 BOOTH #3,66103
-
60 M 1902 87
CAVANAUGH, TIMOTHY B, 3909 ADAMS,66103
-
60 M 1902 86
CHALIAN, ALEXANDER R, 2648 MINNESOTA AVENUE,66102
-
03 M 3509 37 OO
CHANG, C H JOSEPH, KU MED CENTER,66103
588-6807
29 M 58301 53 R
CHENG, MEI Y, KU MED CENTER STUDENT,66103
-
46 F 1902 86
CHIN, CRAIGHTON, 3030 EATON,66103
236-6781
54 M 1902 87
CHIN, TOM D, KUMC - HUMAN ECOLOGY DEPT,66103
588-7175
22 M 2501 43 IO
CHO, CHENG T, K U MED CENTER,66103
588-6336
37 M 38501 62 PD
CHONKO, ARNOLD M, KU MED CENTER,66103
588-6076
43 M 3840 69 NEP
CLABOTS, JOSEPH P, 155 S 18TH, 66102
321-6800
51 M 2802 69 TS
CLABOTS, M. TERESA, KU MED CTR PEDS, 66103
588-6326
54 F 1902 79 PDE
CLARK, CHUCK, 3909 ADAMS,66103
-
60 M 1902 86
CLARK, PERRY L, 3804 BOOTH APT 2,66103
-
63 M 1902 88
CLAWSON, D KAY, K U MED CENTER,66103
588-1400
27 M 2401 52 DRS
COADY, MARY ANN, 3915 BOOTH APT 7,66103
-
59 F 1902 86
COALE, LLOYD H, 5020 GREELEY,66104
-
13 M 1902 43 OO
COLLINS, DAVID E, 3919 ADAMS,66103
-
58 M 1902 87

CODK, JAMES D, KU MED CENTER,66103
588-6077
36 M 6505 60 HEM
CDDKE, ALLAN R, KUMC DEPT OF MED,66103
588-6990
36 M 14303 58 GE
CDDNFIELD, JAMES W, 1428 S 32ND,66106
384-1630
45 M 1902 78 FP
COOPER, CATHY N, KUMC 8DX 3S,66103
-
62 F 1902 86
COX III, IRA L, 155 SDUTH 18TH,66102
371-4343
43 M 1902 68 DR
CRDCKETT, CHARLES A, 155 S 18TH,66102
342-2200
19 M 401 44 OPH
CULP, LOUIS M, 1645 WASHINGTDN 8LVD,66102
371-1077
24 M 1902 53 FP
DADKHAH, NADER, 4145 FRANCIS,66103
-
57 M 1902 87
DARR, RICHARD B, 320 TERRACE TR WEST,66106
676-2097
42 M 3401 70 IM
DAVIS, CHRISTOPHER G, 219 HURDN 8LDG,66101
321-9313
09 M 1902 39 FP
DAY, HUGHES W, 8ETHANY MED CENTER,66102
281-8856
15 M 1902 39 IM
DE SMET, ARTHUR AUGUST, KU MED CENTER - DIAG RAD,66103
588-6800
47 M 2501 72 DR
DE VRIES, PIETER A, KU MED CTR PEDIATRIC SURG,66103
588-6180
21 M 511 47 PDS
DE WITT, 8AR8ARA L, 2913 EATDN,66103
-
63 F 1902 88
DEITZ, MICHAEL R, 155 S 18TH,66102
342-2222
32 M 4101 58 DPH
DELWDRTH, MARK G, 3141 EATDN,66103
262-4548
61 M 1902 88
DEW8ERRY JR, GLENN P, KU MED CTR DEPT OF FP,66103
588-1908
50 M 3901 76 FP
DIALLO, GASTON I, 600 NEBRASKA, 66117
281-2888
35 M 86905 64 GE
DICK, ARTHUR R, KU MEDICAL CENTER,66103
588-6985
34 M 2301 65 N
DIEDERICH, DENNIS A, K U MEDICAL CENTER,66103
588-6981
36 M 2834 61 IM
DDRNHOFFER, JOHN L, 4117 ADAMS,66103
-
62 M 1902 88
DDU8EK, DE88IE L, 3828 ADAMS,66103
-
58 F 1902 86
DUGAN, DAVID L, 1918 W 37TH,66103
-
56 M 1902 87
DUJOVNE, CARLOS A, K U MED CENTER,66103
588-6026
37 M 13201 61 CP
DULIN, JDSE I, 6013 LEAVENWORTH RD,66104
299-0089
51 M 84711 75 IM
DUNN, MARVIN I, KU MED CENTER,66103
588-6015
27 M 1902 54 CD
EDWARDS, SHELLEY J, 4120 THOMPSDN #9,66103
-
59 F 1902 87
EGEA, FERNANDO M, 8919 PARALLEL PARKWAY,66112
334-3400
37 M 13206 62 N
EISEMANN, ALLAN D, 3242 W 43,66103
-
59 M 1902 86
ESTES, NDRMAN C, KU MED CENTER SURG DEPT,66103
588-6150
40 M 1902 71 GS
FABIAN, CARDL J, K U MED CENTER,66103
588-6029
46 F 1902 ON
FAST, GARY A, 4145 ADAMS,66103
-
60 M 1902 88
FERGUSDN, 8EVERLY J, 4129 EATON, 66103
-
54 F 1902 88
FITZPATRICK, M RD8ERT, 1610 WASHINGTDN 8LVD,66102
321-4800
20 M 1803 44 FP
FITZPATRICK, PAMELA S, 3821 SPRINGFIELD APT 18,66103
-
62 F 1902 88
FLDERSCH, HU8ERT M, 8919 PARALLEL PARKWAY,66112
371-2020
08 M 1902 35 D8G
FLUTER, GEDRGE G, 3732 CAMBRIDGE,66103
-
57 M 1902 87
FDRET, JDHN D, KU MED CENTER,66103
588-6147
26 M 1602 53 U
FDSTER, FRANCES J, 4601 DRVILLE SUITE 9,66102
287-2226
41 F 4707 67 OPH
FDX, DEANNA K, K U MED CENTER,66103
588-6670
48 F 1902 74 ANES
FDX, HOWARD A, K U MED CENTER,66103
588-6337
33 M 3501 62 PD
FRANCISCD, W DAVID, 155 S 18TH,66102
371-6802
21 M 1902 44 ORS
FREDRICKSDN, DDREN D, 8DX 56 STUDENT KUMC,66103
-
55 M 1902 86
FRIESEN, STANLEY R, KU MED CENTER,66103
588-6108
18 M 1902 43 GS
FRIESEN, SUSAN G, 3907 SPRINGFIELD,66103
-
60 F 1902 88
FRDST, ELIZA8ETH L, 1058 FOREST CT #16,66103
-
62 F 1902 88
GA8RIELLI JR, WILLIAM F, 4117 ADAMS #101,66103
-
55 M 1902 87
GALLER, GREG WAYNE, 3921 8DDTH #6,66103
-
58 M 1902 86
GEORGE, PAULA Y, 1045 FDRREST CT #17,66103
-
62 F 1902 88
GERJARUSAK, PRAPAS, 8919 PARALLEL SUITE 208,66112
788-9604
46 M 89101 71 IM
GILHDUSEN, FREDERIC M, 1029 N 32ND,66102
281-5252
40 M 1902 66 DRS
GILLETT, MARK L, 3902 8DDTH APT 2,66103
-
33 M 1902 87
GIRDN JR, LOUIS T, K U MED CENTER DEPT DF N,66103
588-6970
43 M 2802 68 N
GLDTZ8ACH, R08IN K, 4131 EATDN,66103
-
55 F 66103 85
GLOVER II, RICHARD M, 3921 8DDTH #9,66103
-
56 M 1902 87
GOERTZ, KENNETH K, 222 HC MILLER KUMC,66103
588-6311
50 M 1902 75 PD
GOERTZ, LED R, 155 S 18TH ST,66102
371-4343
22 M 1902 52 R
GDLDBERG, JDHN M, 3242 W 43RD,66103
-
60 M 1902 87
GOLDSTEIN, ALAN D, 3804 8DDTH APT 3,66103
-
61 M 1902 87
GOLLU8, STEVEN 8, KU MED CTR DEPT DF MED,66103
588-6015
53 M 1205 78 IM
GDNTERD, ELIZA8ETH K M, 3130 EATON,66103
-
59 F 1902 87

GDDDWIN, DDNALD W, KU MED CENTER,66103
588-6402
31 M 1902 64 P
GDDDWIN, JDHN A, 1104 SUNTREE PL 1803,66103
-
50 M 1902 86
GDRMAN, JAMES W, 3804 BDDTH APT 12,66103
-
62 M 1902 88
GDTD, HIRDSHI, KUMC - ANES DEPT,66103
588-6670
42 M 57241 67 ANES
GRA8AU, GUY M, 3749 EATDN,66103
-
54 M 1902 86
GRADY, KENNETH L, 155 S 18TH,66102
321-3844
36 M 1902 69 P
GRANTHAM, JARED J, K U MED CENTER,66103
588-6075
36 M 1902 62 NEP
GREEN8ERGER, N J, KU MEDICAL CENTER,66103
588-6001
33 M 3806 59 IM
GREENWDDD, JDHN M, 3744 8DDTH APT 4,66103
-
52 M 1902 88
GRILLDT, MICHAEL 8, 3921 BDDTH APT 4,66103
-
60 M 1902 88
GRDSWALD, DDUGLAS E, 3744 8DDTH APT 4,66103
-
50 M 1903 88
GRUENDEL, RICHARD A, 1029 N 32ND,66102
281-5252
29 M 1902 55 DRS
GRUENDEL, VIRGINIA T, 6926 GARFIELD,66102
299-2787
30 F 1902 55 FP
GUARDIA, DAVID K, KU MED CENTER DEPT D8/GYN,66103
588-6238
52 M 1902 77 D8G
GUDEMAN, DAVID M, 3838 RAIN8DW APT 809,66103
-
59 M 1902 88
GUMUCID, MARID L, 6013 LEAVENWDRTH RD,66104
299-2069
30 M 64901 63 IM
HALL III, THDMAS 8RYAN, KU MED CENTER,66103
588-6400
43 M 2802 69 P
HAMPEL, KEVIN G, 3138 W 44TH TERR,66103
-
58 M 1902 88
HANCDCK, ALAN C, 9201 PARALLEL,66112
299-1474
35 M 1902 65 FP
HANSDN, FREDERICK, K U MED CENTER,66103
588-6044
48 M 506 74 IM
HARA, GLENN S, KU MED CENTER,66103
588-6200
43 M 514 69 D8G
HARDIN, CREIGHTDN A, KU MED CENTER,66103
588-6106
18 M 5605 43 GS
HARDTEN, DAVID R, 5815 SPRINGFIELD APT A,66103
-
51 M 1902 87
HARPER, DIANE M, 4136 BDDTH,66103
-
58 F 1902
HART, KELLY Z, 155 S 18TH,66102
371-4343
50 M 1902 75 DR
HARTMAN, CHARLES R, K U MED CENTER,66103
588-6111
37 M 1902 66 IM
HARTMAN, GERALD V, KUMC,66103
-
20 M 1902 45 DD
HELENA, WESLEY D, 1931 W LAWRENCE CT,66103
722-0911
58 M 1902 88
HENKE, JEFFREY L, 4117 ADAMS APT 212,66103
-
59 M 1902 86
HENNING JR, HARDLD JDHN, 4116 8DDTH,66103
-
55 M 1902 82 D8G
HERMRECK, ARLD S, K U MED CENTER,66103
588-7232
38 M 1902 65 GS

HIE8ERT, JDHN M, KU MED CTR PLASTIC SURG,66103
588-6143
42 M 2405 67 PS
HINTHDRN, DANIEL R, KU MED CENTER,66103
588-6035
41 M 1902 67 IM
HDADLEY, WILLIAM D, KU MED CENTER-MEDICINE,66103
588-3974
31 M 1902 56 IM
HDDGES, GLENN R, K U MED CENTER,66103
588-6035
41 M 1602 67 ID
HDDGSDN, JAMES F, 8919 PARALLEL,66112
299-8000
45 M 4813 77 D8G
HDLDCRAFT, JACQUELYNE, 255 NEW BRDTHERHDDD 8LDG,66101
321-1161
36 F 2105 63 ENT
HDLMES, FREDERICK F, KUMC,66103
588-6005
32 M 5404 57 IM
HDLMES, GRACE E, KUMC,66103
588-6325
32 F 5404 57 PD
HDLMES, JDHN A, 155 S 18TH,66102
621-1188
47 M 1902 77 IM
HDSTETLER, R08ERT W, 4316 LLDYD,66103
-
55 M 1902 87
HDURIGAN, RICHARD J, 4448 FRANCIS,66103
-
67 M 1902 88
HUERTER, QUENTIN C, WYANDDTTE MED 8LDG STE226,66112
299-8800
31 M 1902 59 DPH
HURL8UT, KEVIN M, 3902 8DDTH APT 7,66103
-
62 M 1902 88
HURWITZ, ARYEH, KU MED CENTER,66103
588-6060
36 M 2802 61 IM
HUTCHISDN, SCDT M, 3902 8DDTH APT 12,66103
-
62 M 1902 88
HUTTERER, ANGELA J, 3804 8DDTH APT 11,66103
-
62 F 1902 88
IBARRA, RICHARD C, 754 PACIFIC, 66101
342-3969
26 M 64902 57 FP
ILIDPDULDS, JDHN I, KU MED CENTER,66103
588-6197
44 M 41801 69 GS
INGRAM, JDHN E, 1428 S 32ND,66106
384-1630
24 M 3006 56 FP
ISERN, HENRY J, 4601 DRVILLE SUITE 9,66102
287-2226
43 M 84706 77 DPH
JACDBS, DAVID S, 8929 PARALLEL PARKWAY,66112
596-4725
31 M 2501 56 PATH
JACDBS, RAE R, K U MED CENTER,66103
588-6163
36 M 3506 62 DRS
JAEGER, MARY G, 3749 BDDTH APT 10,66103
-
62 F 1902 88
JAHANIAN, DARYDUSH, 8919 PARALLEL PARKWAY,66112
334-5420
40 M 51701 64 D8G
JAYARAM, MARANDAPALLI R, 8919 PARALLEL,66112
492-6200
42 M 49509 65 PD
JENKINS, DE ANN R, 1100 CNTY LINE RD #6 BL13,66103
-
62 F 1902 88
JEWELL, WILLIAM R, KU MED CENTER,66103
588-6112
35 M 1611 61 GS
JDHNSDN, BRUCE E, KU MED CENTER,66103
588-6000
50 M 514 76 IM
JDHNSDN, CYNDA A, KU MED CTR FAMILY PRACTIC,66103
588-1908
51 F 514 77 FM
JDHNSDN, JDHN E, BETHANY MED CTR,66102
281-8815
17 M 4706 43 PATH
JDNES, 8ARBARA, KU MEDICAL CENTER,66103
588-6339
28 F 4901 52 PD

JONES JR, HERMAN H, 600 NEBRASKA,66101
342-4010
25 M 4707 54 GS
JORDAN, JANET C, 4171 FRANCIS,66103
-
S3 F 1902 87
JOSLIN, CHARLIE G, 3103 BARNETT, APT C,66102
-
56 M 1902 88
JUSTICE IV, WILLIAM M, 3808 BOOTH #10,66103
-
61 M 1902 88
KALIVAS, JAMES T, KU MED CENTER,66103
588-6028
38 M S02 63 D
KENDALL, CALIN T, 391S BOOTH APT 9,66103
-
62 M 1902 88
KENNEDY, JAMES A, K U MED CENTER,66103
S88-6000
3S M 2834 61 IM
KEPES, JOHN J, K U MED CENTER - PATH DEP,66103
S88-7076
28 M 47301 S2 PATH
KERBY, GERALD R, KU MED CENTER,66103
S88-6044
32 M 1902 S8 PUD
KESTENBAUM, THELDA M, K U MED CENTER,66103
588-6028
48 F S101 73 D
KETCHERSIDE JR, WILLIAM J, KU MED CENTER,66103
-
M
KIM, JONG M, KUMC,66103
588-6670
40 M 58302 64 ANES
KING, CHARLES R, K U MEDICAL CENTER,66103
S88-6200
47 M 1902 71 OBG
KING, TERESA M, 4309 ADAMS,66103
384-S237
S9 F 1902
KIRCHNER, FERNANDO R, 155 S 18TH SUITE 270,66102
371-7333
30 M 64901 55 OTO
KLAUMANN, MICHELLE A, 3808 BOOTH #7,66103
-
59 F 1902 87
KLEIN, THOMAS C, 3724 BOOTH APT 18,66103
-
60 M 1902 88
KOEHN, DANIEL J, 3748 CAMBRIDGE#B,66103
-
61 M 1902 88
KOVAC, ANTHONY L, KU MED CENTER ANES DEPT,66103
S88-6670
S2 M 1902 77 ANES
KRANTZ, KERMIT E, KU MED CENTER,66103
S88-6201
23 M 1606 48 OBG
KRATZ, DONALD P, 4412 STATE LINE,66103
-
61 M 1902 88
KUEBLER, KEVIN M, 155 S 18TH,66102
371-6800
S0 M 2101 75 GS
KUMMER, ANTHONY J, 3732 CAMBRIDGE ,66103
-
61 M 1902 87
KYNER, JOSEPH L, KU MED CENTER,66103
588-6048
34 M 1902 60 END
LAI, CHI-WAN, K U MED CENTER DEPT OF N,66103
S88-7189
44 M 38S02 69 N
LAING, ROBERT R, 1SS S 18TH ST,66102
371-4301
37 M 1643 61 GE
LAWHEAD, JEFF D, 3033 PUCKETT RD #18,66103
-
S7 M 1902 84
LAWHORN, CHARLTON D, 3909 BOOTH APT 9,66103
-
54 M 1902 8S
LAWHORN, STEPHANIE LU, 3909 BOOTH APT 9,66103
722-0691
S4 F 1902
LAWWILL, THEODORE, K U MED CENTER,66103
S88-6605
37 M 4705 61 OPH

LAYBOURNE JR, PAUL C, KU MED CTR, 66103
588-6475
19 M 3509 44 CHP
LEE, JAE M, 155 S 18TH #10S,66102
677-3S55
40 M 58302 65 GS
LEE, KYO R, KUMC,66103
S88-6800
33 M 58302 59 R
LEHMAN, KARL D, 2011 FEDERAL,66103
-
50 M 1902 88
LEMOINE JR, ALBERT N, K U MED CENTER,66103
S88-6600
18 M 2802 43 OPH
LEO, WILLIAM A, K U MED CENTER,66103
588-6109
22 M 1902 48 GS
LEVINE, ERROL, K U MED CENTER,66103
588-6800
41 M 83601 64 OR
LIBEL, ROY, 3740 BOOTH APT 6,66103
-
S8 M 1902 86
LICHTENHAN, JOHN B, 3731 EATON,66103
-
61 M 1902 87
LIEBERMAN, BRUCE IRWIN, KU MED CENTER,66103
S88-6300
49 M 3819 74 PD
LINDSLEY, CAROL B, K U MED CENTER,66103
588-5907
41 F S404 68 PD
LINDSLEY, HERBERT B, K U MED CENTER,66103
588-6008
40 M 1902 66 RHU
LINN, CATHERINE P, 155 S 18TH,66102
788-9797
S2 F 1902 77 OBG
LIU, ALBERT T, 8919 PARALLEL,66112
788-9797
49 M 1902 79 OBG
LIU, CHIEN, K U MED CENTER,66103
S88-6035
21 M 24217 47 ID
LLOYD, HARVEY L, PO BOX 6037,66106
-
08 M 1803 36 EP
LORTZ, PHILIP W, 3628 SPRINGFIELD,66103
-
58 M 1902 88
LUBETICH JR, JOHN F, 3600 RAINBOW SUITE 316,66103
-
57 M 1902 87
LUKERT, BARBARA P, KU MED CENTER,66103
588-6048
34 F 1902 60 END
LYNCH, SEAN R, KU MED CENTER,66103
S88-6031
38 M 83601 61 HEM
MALONE, DAVID G, 3952 ADAMS #24,66103
-
60 M 1902 86
MANGOLD, JOEL VOYCE, KU MED CENTER,66103
S88-6670
S0 M 1902 76 ANES
MANI, MANI M, KUMC,66103
S88-6142
37 M 49S27 60 PS
MARGOLIS, MICHAEL T, 381S BOOTH,66103
-
S7 M 1902 87
MARPLES, BRADLEY W, 3904 ADAMS,66103
384-5643
S6 M 1902
MARSH, ALICE GARRISON, K U MED CENTER,66103
588-6390
24 F 3S45 49 PD
MARTIN, JOSEPH P, 9201 PARALLEL,66112
334-1515
49 M 1902 74 IM
MARTIN, NORMAN L, K U MED CENTER,66103
S88-6800
36 M 1902 62 OR
MARTIN, RONALD L, KU MED CENTER PSYCHIATRY,66103
S88-6412
45 M 1606 71 P
MASTERS, FRANCIS W, KU MED CENTER,66103
588-6142
20 M 3545 45 PS

MATHEWSON, HUGH S, KUMC,66103
588-6675
21 M 1902 44 ANES
MATTIDLI, LEONE, KUMC,66103
588-6311
32 M 56115 56 PDC
MC ALLISTER, SCDTT H, 3909 ADAMS,66103
-
59 M 1902 86
MC FARLANE, MICHAEL J, KU MED CTR DEPT DF MED,66103
588-6063
52 M 1902 78 IM
MC PHEE, MARK S, KU MED CENTER-MEDICINE,66103
588-6001
51 M 1902 76 IM
MCCARTHY, RDBERT P, 155 S 18TH,66102
342-7233
25 M 2834 53 U
MCCUNE, MARK A, 8919 PARALLEL PKWY,66112
492-6200
52 M 1902 77 O
MCHENRY, TERESSA J, 3934 BDDTH APT 9,66103
-
51 F 1902 88
MCKITTRICK, RICHARD, 4117 ADAMS #314,66103
-
59 M 1902 86
MEBUST, WINSTDN K, KU MED CENTER,66103
588-6146
33 M 5404 58 U
MEDHAT, MDHAMED A, KU MED CENTER REHAB MED,66103
588-6798
32 M 33002 54 RM
MEIER, PATRICIA A, 3602 RAINBDW APT 303,66103
-
53 F 1902 88
MENZIE, LISA D, 4318 RAINBDW,66103
-
61 F 1902 88
MESINA, RDLANDD R, 1200 N 38TH,66102
371-3829
37 M 74801 61 GS
MEYERS, JOHN J, 3901 BDDTH APT 3,66103
-
50 M 1902 88
MILLER, CHRISTDPHER D, 3828 BDDTH APT 10,66103
-
61 M 1902 88
MILLER, DENNIS W, 600 NEBRASKA SUITE 102,66101
621-4001
49 M 4707 75 DBG
MILLER, KEVIN B, 3600 RAINBDW SUITE 315,66103
-
60 M 1902 86
MILLER, KEVIN E, 4146 BDDTH,66103
-
59 M 1902 87
MILLIGAN, DONALD B, KU MED CENTER,66103
588-1937
48 M 2307 74 FP
MINER JR, PHILIP B, K U MED CENTER,66103
588-6990
46 M 702 71 GE
MITCHELL, DEANNA SUE, 1100 COUNTY LINE R B-9,66103
-
60 F 1902 87
MOELLER, DDNALD D, 155 S 18TH,66102
371-4301
34 M 1902 60 GE
MDDRE, WAYNE V, K U MED CENTER,66103
588-6336
42 M 2604 70 PD
MDRFFI, RAUL R, 1225 N 78TH,66112
287-8300
25 M 27501 51 IM
MUELLER, MICHAEL A, 3602 RAINBOW #306,66103
-
60 M 1902 86
MULLEN SR, CLIFFORD J, 1828 WASH BLVD,66102
-
98 M 3006 23 DD
MURPHY, WILLIAM R, 3740 BDDTH #8,66103
-
59 M 1902 87
NADER, DADKAH, 4145 FRANCIS,66103
-
57 M 1902 87
NEFF, JAMES R, KU MED CENTER,66103
588-6198
40 M 1902 66 DRS
NEIGHBDR, ERNEST G, 1420 S 42ND,66106
-
06 M 1902 33 FP
NEIGHBDR, ERNEST H, 1420 S 42ND,66106
831-3433
40 M 1902 66 DRS
NEIGHBDR, GAYLDRD P, 1420 SDUTH 42ND,66106
831-3433
13 M 1902 41 FP
NELSON, BRENDA S, 4440 EATDN,66103
-
57 F 1902 86
NELSON, NANCY A, 3736 CAMBRIDGE,66103
-
61 F 1902 87
NIBBELINK, LARRY WAYNE, 155 S 18TH,66102
371-2330
48 M 2803 75 OBG
NIXDN, DAVID W, 2525 ESSEX,66103
-
59 M 1902 88
NOBLE, MARK J, KU MED CENTER-URDLDGY,66103
588-6148
49 M 2501 75 U
NORRIS, CHARLEY W, KUMC,66103
588-6700
33 M 1902 64 DTD
NDTHNAGEL, ARNDLD F, 501 WESTVALE,66102
-
15 M 1902 39 DO
D'BOYNICK II, PAUL LEDNARD, KU MED CENTER,66103
588-5000
48 M 1902 73 NS
O'DELL, MICHAEL L, KU MED CTR DEPT DF FP,66103
588-1908
51 M 1902 77 FP
D'DDNNELL, JANAT E, 4318 RAINBDW,66103
-
59 F 1902 88
DTHMER, EKKEHARD, K U MEDICAL CENTER,66103
588-6440
33 M 40721 66 P
DVERFIELD, A SCDTT, 3838 RAINBDW #906,66103
-
57 M 1902
OWENS, RICHARD L, 720 OAK, 64106
842-1146
24 M 3006 51 OM
DXLER JR, JOHN EDWARD, 155 S 18TH,66103
362-6161
46 M 1902 72 IM
PAIGE, ANGELA A, 2424 W 40TH APT 5,66103
-
62 F 1902 88
PALMER, MARVIN M, 8919 PARALLEL PKW,66112
788-9797
45 M 702 71 DBG
PARDD, LILLIAN G, KU MEDICAL CENTER,66103
831-6373
39 F 74802 62 PDN
PARDD, MANUEL P, K U MEDICAL CENTER,66103
588-6464
35 M 74801 62 P
PAREKH, AJITKUMAR M, 6013 LEAVENWDRTH RD,66104
299-2069
47 M 49501 71 PUD
PARK, CHAN H, K U MEDICAL CENTER,66103
588-6029
36 M 58302 62 IM
PARKER, JULIE A J, 4121 THDMPSDN APT 8,66103
-
61 F 1902 87
PARRA, DANIEL C, 6013 LEAVENWDRTH RD,66104
299-2069
43 M 84703 75 FM
PARRA, MIGUEL D, 6013 LEAVENWORTH RD,66104
299-2088
37 M 84710 64 FP
PATRON, RICARDD F, 3900 BDDTH APT 9,66103
-
61 M 1903 88
PAULS, DAVID G, 3900 BOOTH APT 4,66103
-
62 M 1902 88
PAZELL, JOHN A, 4631 ORVILLE,66102
287-6464
40 M 2501 66 DRS

PENNER, TIMOTHY M. 3700 CAMBRIDGE.66103
-
59 M 1902
PERRY JR, LAWRENCE L. KUMC 39TH AT RAINBOW.66103
588-6522
34 M 1902 59 FP
PETERS, ERIC A. 3934 BOOTH APT 4.66103
-
62 M 1902 88
PIERCE, GEORGE E. KUMC - PO BOX 255.66103
588-6115
33 M 2307 60 TS
PINGLETON, SUSAN K. KU MED CENTER DEPT OF MED.66103
588-6044
46 F 1902 72 IM
PINKERTON, LYNNE E. 2019 DOUGLAS.66103
-
60 F 1902 88
PIPPIN, LYNNE K. KU MED CENTER ANES.66103
588-6670
48 F 35207 72 ANES
POOREBARAC, FRANCIS A. 3909 BOOTH APT 4.66103
-
59 M 1902 86
POOLE, EDWARD C. 3516 STATE LINE.66103
-
60 M 1902 88
PORTER, DAVID M. 4517 TROUP.66102
287-8800
39 M 4707 64 PD
PORTER, SUSAN S. KU MED CTR ANES DEPT.66103
588-6670
54 F 1902 79 ANES
POTTER, ROBERT L. 1969 N 33RD.66102
321-0341
38 M 1902 64 IM
POWERS, G ROBERT. 8919 PARALLEL PKWY.66112
299-1469
33 M 1902 65 FP
PREMSINGH, NALINI G. 4631 DRVILLE #202.66102
596-2000
39 F 49508 65 CD
PRESTON, DAVID F. KU MED CENTER.66103
588-6810
33 M 3841 59 NM
PRETZ, JAMES B. 1610 WASHINGTON BOULEVARD.66102
342-2442
24 M 1902 47 FP
PRICE, HILTON I. KU MED CENTER - RAD DEPT.66103
588-6831
49 M 83601 72 DR
PRICE, JAMES GORDON, K U MED CENTER.66103
588-6510
26 M 702 47 FP
PRIETO, JORGE N. 6013 LEAVENWORTH RD.66104
299-2069
45 M 26401 69 GS
PROUD, G ONEIL. KU MEDICAL CENTER.66103
588-6700
13 M 2802 39 OTO
PUCKETT, MICHAEL L. 1851-B S 31ST.66106
-
60 M 1902 87
PUGH, DAVID M. K U MED CENTER.66103
588-6015
29 M 801 58 CD
QUINN, CHARLES E. 4601 DRVILLE.66102
287-6604
43 M 4707 68 DBG
RAGLAND, CHARLES W. 155 S 18TH.66102
321-2974
50 M 1902 77 IM
RAYHACK, JOHN M. KU MED CENTER ORS DEPT.66103
588-6134
50 M 3305 78 DRS
RECKLING, FREDERICK W. KUMC.66103
588-6129
34 M 3545 59 DRS
REDDY, EASHWER K. K U MED CENTER - RAD DEPT.66103
588-7350
44 M 49597 68 TR
REDFORD, JOHN W B. K U MED CENTER.66103
588-6777
28 M 6501 53 PM
REEB, RONALD JOSEPH. 155 S 18TH.66102
371-4343
46 M 3006 72 DR
REED, JAMES STEWART. K U MED CENTER.66103
588-6019
46 M 3601 72 GE
REED JR, WILLIAM O. 155 S 18TH.66102
371-6805
50 M 2803 77 DRS
REEDER, STEPHEN M. 3838 RAINBOW #404.66103
-
61 M 1902 87
RETHORST, RICHARD O. 4120 THOMPSON #20.66103
-
61 M 1902 87
REYNOLDS, MIKE G. KUMC BOX 138.66103
-
61 M 1902 88
RHOADS, DANIEL D. 3101 S SEVENTH.66103
-
50 M 1902
RHODES, JAMES B. KU MEDICAL CENTER.66103
588-6019
28 M 1902 58 GE
RHODES, MARTIN L. 155 S EIGHTEENTH.66102
321-0341
47 M 1902 72 IM
RICE JR, FREDERICK A. 1029 N 32ND ST.66102
281-5252
36 M 4802 63 ORS
RICH, GARY L. 3014 W 42ND #14.66106
-
55 M 1902 87
RICHARDSON, CATHERINE A. 2400 W 38TH #4.66103
-
49 F 1902 86
RICHARDSON, JAY L. 8919 PARALLEL.66112
299-8000
38 M 1902 65 GS
RILEY, RAY B. 2020 DRVILLE.66102
-
06 M 1902 36 OD
RISING, JESSE D. KU MEDICAL CENTER.66103
588-1934
14 M 1902 38 IM
ROBINSON, DAVID W. KU MEDICAL CENTER.66103
588-6136
14 M 4101 38 PS
ROBINSON, RALPH G. KU MEDICAL CENTER.66103
588-6810
37 M 1902 62 NM
ROBINSON, RICHARD K. 2904 W 46TH.66103
-
54 M 1902 88
ROME, MICHAEL P. 3815 BOOTH.66103
-
60 M 1902 87
RONSICK, STEVEN D. 3722 BOOTH #13.66103
-
62 M 1902 88
ROOK, LEE E. 4116 STRONG.66106
831-2834
09 M 1902 38 FP
ROSENTHAL, STANTON J. K U MED CENTER.66103
588-6800
46 M 1902 71 OR
ROTH, ALAN E. BETHANY HOSPITAL 51 N 12.66102
281-8814
35 M 1902 62 PATH
ROY, RISE J. 4212 ADAMS.66103
-
59 F 1902 88
RUBIN JR, BEN. 132 S SEVENTEENTH.66102
371-2561
37 M 3005 61 PD
RUSSO, LIBBIE J. KU MED CENTER.66103
588-6326
53 F 2846 77 POE
RUTH, WILLIAM E. K U MED CENTER.66103
588-6044
26 M 1902 53 PUD
RYAN, MICHAEL J. 764 NEW BROTHERHOOD BLDG.66101
342-7070
14 M 2834 37 OTO
RYAN, SHERRY L. 920 HOMER.66101
-
50 F 1902 88
SANDNESS, KATHLEEN M. 2520 W 46TH.66103
-
56 F 1902 88

SANTOS, FERMIN M, 6013 LEAVENWORTH RD,66104
299-0538
49 M 84706 77 P
SAVIN, VIRGINIA J, KU MED CENTER,66103
588-6983
44 F 4112 70 IM
SAYEGH, JOHN, 1332 SOUTH 42ND,66106
321-2420
46 M 84701 78 GP
SCHIMKE, R NEIL, KU MED CENTER,66103
588-6043
35 M 1902 62 IM
SCHOELING, RICK O, 4458 EATON,66103
-
59 M 1902 86
SCHOWENGEROT, ANDREW W, 4101 FRANCIS,66103
-
52 M 1902 88
SCHROFF, GREGORY P, 3730 BOOTH APT 11,66103
-
60 M 1902 88
SCHULMAN, STACEY J, 3804 BOOTH APT 11,66103
-
62 F 1902 88
SCHUYLER, GREGG T, 3807 BOOTH,66103
-
58 M 1902 90
SCHWEGLER, RAYMOND A, 8919 PARALLEL PKWY,66112
492-6200
37 M 1902 63 CD
SCHWORM, CURTIS P, 155 SOUTH 18TH,66102
371-4343
47 M 3005 73 OR
SEIFERT, EARNEST O, K U MED CENTER STUDENT,66103
-
56 M 1902 87
SERERES, EDGAR P, 733 N 75TH TERR,66112
299-9010
15 M 1902 39 FP
SEYB, STACY T, 3711 CAMBRIDGE,66103
-
61 M 1902 88
SHAW, HOWARD A, 30 S 58TH LANE,66102
-
61 M 1902 88
SHAW, PAMELA K, 3909 BOOTH #11,66103
-
60 F 1902 86
SHERMAN, DENISE I, 3838 RAINBOW #511,66103
-
51 F 1902 88
SHERMAN, ROBERT P, 9201 PARALLEL AVE,66112
334-0040
34 M 1902 63 PUD
SIEG, KARL G, 3909 BOOTH APT 4,66103
-
61 M 1902 86
SIFERS, TIMOTHY M, 155 S 18TH,66102
371-2900
48 M 1902 74 GS
SIMON, CRAIG A, PO BOX 3141,66103
-
61 M 1902 88
SKIKNE, BARRY S, KU MED CENTER,66103
588-6031
45 M 83601 61 HEM
SMITH, WILLIAM E, 3828 BOOTH APT 10,66103
-
62 M 1902 88
SNIDER, BRUCE B, 4464 FISHER,66103
-
59 M 1902 86
SNYDER, MARK G, 4022 ADAMS,66103
-
61 M 1902 88
SOMMERFIELD, DAVID L, 4455 EATON,66103
-
60 M 1902 86
SOUCEK, CHARLES D, 155 S 18TH,66102
371-4343
31 M 3005 56 R
SOUTHERN, FREDRICK N, 3838 RAINBOW APT 103,66103
-
60 M 1902 87
SPEER, LELAND, 910 N WASHINGTON,66102
-
12 M 1902 36 OD
SPILKER, CYNTHIA A, 3736 CAMBRIDGE,66103
362-4251
62 F 1902 88
SPRINGER, MARK J, 3126 EATON,66103
-
61 M 1902 87
STANLEY, BRAD K, 3141 EATON,66103
-
62 M 1902 88
STARKEY, DAVID J, 3734 CAMBRIDGE,66103
-
60 M 1902 86
STARR, STEVEN K, 3820 BOOTH APT 10,66103
-
62 M 1902 88
STECHSCHULTE, DANIEL J, K U MED CENTER,66103
588-6008
36 M 2834 62 A
STEELE, CLARENCE H, 255 BROTHERHOOD BLDG,66101
321-1161
14 M 1902 40 OTO
STEINZEIG, SHERMAN M, 155 S 18TH,66102
621-1151
25 M 1902 52 CO
STEPHENS, RONALD L, KUMC,66103
588-6029
39 M 1902 65 IM
STONE, CHRIS O, 1930 W 36TH,66103
-
83 M 1902 87
STRONG, BRADLEY W, 3915 BOOTH APT 8,66103
-
62 M 1902 88
STUART, SCOTT P, 1832 SOUTH 32ND,66106
432-4404
61 M 1902 87
STUBBLEFIELD, CHARLES T, 155 S 18TH,66102
371-2330
32 M 1902 58 OBG
STUBLER, DANIEL K, 3942 ADAMS APT 17,66103
-
59 M 1902 59
SUTTON, JEFFREY J, 143 S 58TH DR,66102
-
55 M 1902 88
TARANTINO, CELESTE A, 3704 CAMBRIDGE, 66103
--
62 F 1902 88
TAYLOR, ONEITA F, 1863 SOUTH 31ST,66106
588-3600
46 F 1902 81 RT
TAYLOR, SARAH A, KU MED CENTER-STUDENT UN,66103
588-6029
50 F 1902 75 IM
TAYLOR, WILLIAM F, 8919 PARALLEL PKWY,66112
299-8000
53 M 2846 76 IM
TEETER, CAROLYN NAN, 3708 CAMBRIDGE,66103
-
62 F 1902 88
TEETER, MARILYN A, 3708 CAMBRIDGE,66103
-
62 F 1902 88
TEMPLETON, ARCH W, K U MEDICAL CENTER,66103
588-6805
32 M 3005 57 R
TETER, KENNETH E, 3124 EATON, 66103
--
62 M 1902 88
THEOINGER, BRADLEY S, KU MED CTR DEPT OF OTO,66103
588-6717
53 M 1902 76 NOTO
THEROU, LEONA F, K U MED CENTER PED DEPT,66103
588-5908
41 F 6701 67 PD
THOMAS, JAMES H, K U MED CENTER,66103
588-5901
41 M 2012 66 GS
THOMPSON, DANNIE M, TWO GATEWAY CTR SUITE 917,66101
321-3355
35 M 4707 64 OBG
THOMPSON, JEFFREY D, 3811 SPRINGFIELD APT C,66103
384-6325
62 M 1902 88
THORNTON III, FOXHALL P, 3902 BOOTH APT 7,66103
-
62 M 1902 88
TIOJANCO, REYNALDO R, 6013 LEAVENWORTH RD,66104
799-2069
44 M FP
TORREY, ELIZABETH A, 3907 SPRINGFIELD,66103
-
60 F 1902 87
TRUEWORTHY, ROBERT C, KU MED CENTER,66103
588-6340
40 M 2802 66 PD
TSEN, ANDREW C, 3733 EATON,66103
-
63 M 1902 88

TURNER, ROBERT N, 3740 BOOTH APT 1,66103
677-4550
59 M 1902 87
TURNER, WADE A, 3821 CAMBRIDGE,66103
-
50 M 1902 88
VAN ODREN, BRYAN A, 3600 RAINBOW APT 315,66103
-
60 M 1902 86
VAN THULLENAR, PHILIP A, BETHANY MED CENTER,66102
281-8834
31 M 2834 57 PATH
VARGHESE, GEORGE, K U MEDICAL CENTER,66103
588-6798
44 M 49509 69 PM
VATS, TRIBHAWAN S, K U MED CENTER PED DEPT,66103
588-6340
40 M 49529 63 PD
VELARDE, HUGO, 4601 ORVILLE AVE STE 14,66102
287-8400
M 64 GS
WADDELL, BILL D, 155 SOUTH 18TH,66102
321-0386
31 M 3901 56 IM
WALASZEK, SHEILA J, 3718 STATE LINE,66103
-
59 F 1902 85
WALKER, ANDY E, 3617 CAMBRIDGE,66103
-
61 M 1902 87
WALKER, JACK D, KU MED CENTER,66103
588-1900
22 M 1902 53 FP
WALKER, MAURICE A, 3214 STRONG AVE,66106
831-1433
04 M 1601 28 GS
WALSH, DAVID J, KU MED CENTER PED DEPT,66103
588-6371
46 M 4501 73 PD
WALTERS, WILLIAM DAVID, 1428 S 32ND,66106
384-1630
50 M 1902 78 FP
WAMSLEY, CRAIG A, 1888 S 32ND SUITE B,66106
-
58 M 1902 86
WARDEN, SUSAN K, 3038 EATON,66103
-
55 F 1902 88
WARNER, CLAUDE A, BOX 191 39TH & RAINBOW,66103
-
52 M 1902 88
WEIGEL, JOHN W, UROLOGY DEPT KU MED CTR,66103
588-6148
29 M 1902 54 U
WEINMEISTER, DONALD D, 3739 CAMBRIDGE,66103
-
55 M 1902 86
WEINSTEIN, GARY L, 3824 BOOTH #9,66103
677-1563
M 1902
WEISHAAR, PAUL D, 2311 MARTY APT 4,66103
-
62 M 1902 88
WELLER, ELIZABETH B, KU MED CENTER,66103
588-6464
49 F 60501 75 CHP
WELLER, RONALD ALAN, KU MED CENTER - PSY DEPT,66103
588-6464
48 M 2802 74 P
WETZEL, MARK D, 4172 CAMBRIDGE,66103
-
59 M 1902 86
WHITCOMB, RANDALL W, 4141 ADAMS,66103
-
54 M 1902 81 IM
WHITFIELD, STEVEN S, 3806 STATE LINE,66103
-
56 M 1902 82 IM
WIENS, JONATHAN G, 4117 ADAMS APT 213,66103
-
60 M 1902 86
WILLIAMS, NANCY J, 3816 STATE LINE,66103
-
60 F 1902 87
WILLIAMS JR, STERLING B, K U MEDICAL CENTER,66103
588-6200
41 M 401 73 OBG
WISE III, JOSEPH EDWARD, 132 S 17TH,66102
371-2561
51 M 1902 76 PD
WISNER JR, JOHN HENRY, 229 S EIGHTH,66101
588-6431
46 M 1902 76 P

WOLF, KARL T, 621 NORTHRUP AVE,66101
-
14 M 1902 48 OD
WOODROOF, JANET M, 4124 THOMPSON #11,66103
-
56 U 1902 87
WRIGHT, CHRISTOPHER, 3733 EATON,66103
-
61 M 1902 87
WRIGHT, MICHAEL J, 2911 W 42ND,66103
-
59 M 1902 88
ZAREMSKI, SHERMAN C, 4631 ORVILLE STE 209,66102
596-1185
33 M 1720 58 IM
ZECHMANN, JEROME P, 3915 BOOTH APT 8,66103
-
62 M 1902 88
ZIEGLER, DEWEY K, KU MED CENTER,66103
588-6985
20 M 2401 45 N
ZIMBELMAN, ROD D, 3909 BOOTH APT 12,66103
-
61 M 1902 87
ZINN, THOMAS W, 155 S 18TH,66102
371-4343
41 M 1902 67 R

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ADAMS, JOYCE A, 6106 HARRISON,64110
588-6325
50 F 1902 77 PD
AGIAR, MARY C, 948 W 33RD TERR,64111
561-4755
55 F 1902 88
AHMED, IFTEKHAR, 2900 BALTIMORE #390,64108
756-2651
45 M N
ALLEN, MARK L, 8301 STATE LINE SUITE 200,64114
361-7555
53 M 1902 80 ANES
BARELLI, PAT A, 2929 BALTIMORE,64108
-
19 M 1902 44 ENT
BECK JR, CALVIN E, 808 W 99TH,64114
-
59 M 1902 87
BENNETT, CHARLES A, 5619 NW HILLSIDE DR,64151
-
96 M 1902 25 OD
BENNETT, S H, 3630 BELL 3RD FL,64111
-
61 M 1902 88
BLIM, R DON, 4400 BROADWAY,64111
561-8100
27 M 1902 53 PD
BRIDGENS, JAMES G, 1025 HUNTINGTON RD,64113
-
22 M 1902 47 PATH
CHRISTENSEN, SHANE R, 4481 2 HEINTZ,64133
281-8881
55 M 1902 79 EM
CLAY, MICHAEL J, 1717 1/2 WESTPORT RD,64111
-
58 M 1902 87
COLLINS, JEFFREY S, 4333 OAK APT 3,64111
-
62 M 1902 88
COLYER, JEFFREY W, 1111 W 46TH,64112
625-3291
60 M 1902 86
CRABB, JEREMIAH E, 3630 BELL,64111
531-6001
54 M 1902 79 IM

DAVIDNER, MARK L, 6724 TROOST #700, 64131
--
43 M 68 HEM

DE JONG, JOHN THEODORE, 3716 BELL,64111
-
59 M 1902 86
DEVINS, GEORGE S, 6700 TROOST #520,64131
-
36 M 1902 62 IM

DIEHL, ANTONI M, 4320 WORNALL RD,64111
753-4414
24 M 2604 47 PDC
DINGES, DAVID L, 4603 BELL,64112
-
62 M 1902 88
DO, SON T, 4123 TERRACE APT 2 NE,64111
-
61 M 1902 86
EHLY, CHRISTOPHER J, 5301 LYDIA,64110
-
61 M 1902 88
EMIG, MARK D, 4603 BELL,64112
-
61 M 1902 88
FANSHIER, SHAWNETTE L, 3739 GENESSE,64111
-
61 F 1902 88
FRECHETTE, ALAN R, 3560 BROADWAY #S06,64111
-
57 M 1902 87
GLATTER, THOMAS R, VA HOSPITAL,64128
861-4700
34 M 1611 60 IM
GODFREY, WILLIAM A, 4320 WORNALL RD,64111
588-6600
38 M 1902 65 OPH
GRAHAM, WALLACE H, 6724 TROOST SUITE 304,64131
363-6707
10 M 3006 GS
GUASTELLO, MARIO J, 4320 WORNALL,64111
753-5663
38 M 1902 63 OTO
HAGMAN, JENNIFER O, 4455 JEFFERSON #14,64111
561-6499
60 F 1902 86
HAMILTON, WILLIAM A, 3730 WYOMING,64111
-
58 M 1902 86
HARD, BENJAMIN F, BOX 4913 HAWTHORN RD,64120
242-2674
28 M 4802 55 OBG
HAYES, DAVID M, 3729 STATE LINE,64111
-
55 M 1902 BS
HEIM, MARY LEE, 9308 NW 80TH TERR,64152
598-4184
42 F 2846 76 EM
HOHLY, EVE K, 3923 HARRISON,64110
-
40 F 1902
HOPKINS, JAMES P, 6650 TROOST,64131
523-7811
22 M 2407 58 PS
HUGHES, STEVEN, 4326 WYOMING,64111
-
45 M 1902 87
HYMAN, HENRY T, O.D., 5500 N OAK SUITE 201,64118
452-7300
49 M 2879 76 OBG
JACKSON, ROGER P, 2700 HOSPITAL,64116
-
47 M 2803 73 ORS
JOHNSON, TERESA F, 4122 BELL,64111
-
55 F 1902 81 GS
KAHRS, GREG, 3827 TERRACE #10, 64111
--
58 M 1902 88
KENNEDY, CHRISTOPHER S, 3708 WYOMING,64111
-
58 M 1902 88
KINDRED, LYNN H, 4320 WORNALL RD STE 40-II,64111
531-5510
37 M 1902 63 CD
KINPORTS JR, EDWARD B, 3212 CENTRAL AVE,64108
842-1950
46 M 3006 74 EM
KINPORTS SR, EDWARD B, 3212 CENTRAL,64108
-
15 M 1602 42 OO
LESSIN, DIANNA L, 3621 WYOMING,64111
-
55 F 1902 87
LEWIS JR, H DANIEL, VETERANS MEDICAL CENTER,64128
861-4700
32 M 5101 58 CD
LILLICH, MAUREEN A, 323 BRUSH CREEK #607,64112
-
59 F 1902 86
LOVETT, BRENT R, 3622 WYOMING SUITE 1N,64111
-
59 M 1902
LUCKEROTH, LEAH L, 323 BRUSH CREEK #607,64112
-
58 F 1902 86
LUETJE, CHARLES MARION, 2940 BALTIMORE,64111
531-7373
41 M 2803 67 OTO
MCCLEAY, PETER D, 4415 JEFFERSON APT 4,64111
-
62 M 1902 88
MCGURK, THOMAS E, 323 W 119TH TERR,64145
649-2080
39 M 2803 6S P
MCVEY, PAMELA S, 3217 KARNES BLVD,64111
842-1950
56 F 1902 80 EM
MILLS, MELISSA J, 442 GREENWAY TERR,64113
444-3501
57 F 3605 83 IM
MUKERJEE, SANDEEP, 1135 W 41ST APT 1,64111
-
61 M 1902 88
MURPHY, TIMOTHY P, 4730 JARBOE, 64112
--
53 M 1902 87
NEUFELD, BRENDA G, 3717 STATE LINE,64111
-
62 F 1902 88
ORR, STEVEN M, 4544 N OLIVE,64116
-
55 M 1902 79 EM
PAYNE, J RALPH, 3212 CENTRAL, 64111
334-2500
40 M 1902 62 EM
PERSONS, DIANE L, 1002 W 78TH,64114
-
52 F 1902 87
PINKHAM, CHRIS M, 5311 HARRISON,64110
-
53 M 1902 87
PRUITT, DAVID E, 5301 LYDIA,64110
-
62 M 1902 88
RIGGS, SANDRA L, 3744 WARWICK SUITE 2,64111
-
58 F 1902 87
RITCHIE, KAREN S, MIDWEST BIOETHICS,64131
722-0080
49 F 3840 73 P
RYSER, CAROL A, 7447 HOLMES,64131
363-3313
37 1902 63
SALEH, GEORGE A, D.O., 5500 N OAK SUITE 201,64118
452-7300
50 M 2878 OBG
SANDERS, JAMES E, 3725 STATE LINE,64111
-
51 M 1902 86
SCHLOESSER, ANNE C, 5920 MC GEE,64113
-
62 F 1902 88
SCOTT, STEVE G, 1310 MANHEIM,64109
-
51 M 1902 86
SHECHTER, NATHAN, 6724 TROOST,64131
333-1700
18 M 1611 43
SINGER, PHILIP A, V A HOSPITAL,64128
861-4700
42 M 3545 69 N
SLAVIK, MILAN, V A HOSP,64128
588-3302
30 M 28602 60 ON
STASS-ISERN, MERRILL, 1405 W 50TH TERR,64112
281-8880
50 M 84706 77 EM
STOKES, ROBERT LEE, 3621 BELLEVIEW,64111
281-8882
43 M 4804 74 EM
STUEVER, KEVIN J, 4603 BELL,64112
-
62 M 1902 88
TEARE, MARIJO, 1804 W 41ST APT 1E,64111
-
60 F 1902 87
UTLEY, JAMES HARMON, 4951 WESTWOOD TERR,64112
281-8880
51 M 1606 74 EM
VASUDEVAN, GOPI, 3471 A WYOMING,64111
-
60 M 1902 86

WESSELIUS, LEWIS J, VA HOSPITAL,64128
861-4700
50 M 1902 82 PUD
WIEGMANN, THOMAS B, VETERANS MED CENTER,64128
-
43 M 40902 69 NEP
WIENS, LYNN A, 3824 BELL #15, 64111
--
M 1902 87
WRIGHT, TIMOTHY F, 3716 BELL,64111
-
60 M 1902 88
YOST JR, JOHN G, 6420 PROSPECT,64132
444-9000
53 M 3005 78 ORS

KINGMAN—316
(Ninnescah Society)

BLOOM, L THEIL, BOX 496,67068
-
32 M 1902 57 R
BOYER, ROBERT E, 760 AVENUE D WEST,67068
532-5145
36 M 1902 63 FP
BURKET JR, GEORGE E, SPRING LAKE RTE 1,67068
-
12 M 1902 37 OO

KINSLEY—316
(Iroquois County Society)

ATWOOD, M DALE, 616 NILES,67547
659-2114
19 M 1902 51 FP
SCHNOEBELEN, RENE E, 807 EAST 4TH,67547
659-2141
16 M 3901 40 FP

KIOWA—316
(Tri-County Society)

CHRISTENSEN, MARION D, 220 SOUTH EIGHTH,67070
825-4121
25 M 3901 52 FP

LA CROSSE—913
(Central Kansas Society)

BHARGAVA, ASHOK KUMAR, PO BOX 490,67548
222-2564
37 M 49547 64 FP
BHARGAVA, SHOBHANA, PO BOX 490,67548
222-2564
38 F 49547 64 FP

LARNED—316
(Pawnee County Society)

CRAM JR, OLE R, 521 CARROLL,67550
285-3161
18 M 1902 43 FP
DAVIS, DAVID H, 815 W 6TH,67550
-
04 M 1902 30 OO
EWING, THOMAS D, 804 CARROLL,67550
285-3133
22 M 1902 46 FP
SHAH, MIAN, SHAH CLINIC,67550
285-3173
32 M 70403 58 GS
SHAH, NASREEN, SHAH CLINIC,67550
285-3173
39 F 70409 62 OBG
SHEPARD, LEROY W, 603 W 5TH,67550
-
04 M 3006 30 OO
SMITH, JOHN D, 804 CARROLL,67550
285-3133
22 M 3901 51 FP
WAGNER, LENARD D, PO BOX 300,67550
-
54 M 512 79 FP

LAWRENCE—913
(Douglas County Society)

BAILEY, WILLIAM A, PO BOX 127,66044
843-9125
40 M 1902 66 ORS
BELOT JR, MONTI L, LAWRENCE NATIONAL BK BLDG,66044
843-3640
13 M 1902 40 FP
BIERI, PETER V, 1112 W SIXTH ST,66044
841-5217
45 M 1902 71 ENT
BISHOP, RODNEY LEE, LAWRENCE IM ASSOC,66044
842-7200
49 M 1902 75 IM
BITTENBENDER, LEE R, 930 IOWA,66044
842-7001
46 M 1902 72 D
BOYDEN, MARY S, MEDICAL ARTS BLDG,66044
842-3778
14 F 2604 38 PDA
BRANSON, VERNON L, 346 MAINE,66044
842-4477
17 M 1902 42 PD
BRUNFELDT, JOAN KRAUS, 404 MAIN,66044
842-3635
52 F 1902 77 IM
BUCK JR, HENRY W, 1112 W SIXTH,66044
841-9200
34 M 1902 60 OBG
CHEDIAK, ELIAS, 601 MISSOURI,66044
841-7430
39 M 84704 65 P
CLINTON, DALE L, 15 E SEVENTH SUITE 103,66044
841-5716
21 M 1902 54 GP
CULVER, WARREN T, 3506 W TENTH,66044
-
20 M 3508 46 OO
DUNLAP, RICHARD L, MEDICAL ARTS CENTER,66044
842-4344
12 M 3005 37 EENT
FRIESEN, DALE, PO BOX 521,66044
842-7026
47 M 1902 74 ANES
FUNK, EDWARD D, 2725 MAVERICK LN,66046
441-2646
04 M 1902 41 ANES
GILLES, HELEN M, 1301 IOWA,66044
-
22 F 1902 45 OO
GODWIN, PHILLIP A, 500 ROCKLEDGE,66044
841-6540
28 M 1902 55 ANES
GRAY, SCOTT E, 346 MAINE,66044
843-0677
50 M 1902 79 OBG
HAGGAN, MARGARET E, 1746 N H,66044
-
F 2501 42 OO
HASSELLE III, JAMES E, 601 MISSOURI,66044
841-7430
35 M 4706 59 P
HATTON, DONALD W, 404 MAINE ST,66044
842-3635
42 M 1902 68 IM
HERMES, RICHARD L, THE MEDICAL ARTS CENTER,66044
843-0677
15 M 4112 39 OBG
HIEBERT, DAVID L, 1112 W SIXTH,66044
841-3211
36 M 1902 61 R
HUGHES, ROBERT WALTER, MEDICAL ARTS BLDG,66044
843-1374
27 M 1902 54 FP
INGHAM JR, H LAIRD, 404 MAINE,66044
842-3635
45 M 3901 70 IM
JONES, H PENFIELD, MED ARTS CENTER,66044
-
06 M 2401 31 GS
JOSEPH, HOWARD F, 308 MAINE,66044
843-3981
26 M 1902 51 U
JOSPEH, ROSE, 419 MINNESOTA,66044
-
44 M
KEELER, LINDA L, MTL HLTH CL WATKINS MEM,66044
-
47 F 1902 76 P

LEARNED, GEORGE R, 401 ARKANSAS,66044
843-5502
22 M 1902 55 GS
LESSENDEN, GLENN A, 1112 W SIXTH SUITE 110,66044
843-6233
24 M 1902 48 FP
LOVELAND, G CHARLES, 346 MAINE,66044
842-4477
47 M 1902 73 PD
MADSEN, GLENN L, 1112 W SIXTH,66044
841-3211
38 M 3005 65 R
MAGEE, LAWRENCE M, 233 DAKOTA,66044
841-4699
52 M 1902 77 FP
MANAHAN, G EUGENE, MED ARTS CENTER,66044
842-0211
19 M 1902 44 GS
MITCHELL, ALEX C, 1626 W 20TH,66044
843-4739
18 M 1902 50 PH
MODDRELL, CARDL A, 404 MAINE,66044
749-6100
45 F 1902 71 PATH
MONCKTON, LAJRANCE A, 1112 W SIXTH SUITE 204,66044
843-2010
48 M 1902 74 GS
MYRICK, STEPHEN W, 346 MAINE,66044
842-6644
52 M 1902 77 GS
NELSON, RICHARD D, 935 IDWA,66044
843-0921
11 M 1001 41 FP
OELSCHLAGER, RONALD D, 1112 W SIXTH,66044
841-3211
43 M 1902 69 R
OLSON, CARL E, 935 IDWA,66044

17 M 1611 46 OO
ORCHARD, RICHARD A, 1112 W SIXTH SUITE 202,66044
841-2280
41 M 2802 68 OPH
OSBERN, LIDA, 404 MAINE,66044
842-3635
52 F 1902 77 IM
PEES JR, GERALD BDYD, 1112 W SIXTH SUITE 210,66044
843-5160
45 M 1902 71 IM
PLACEK, DEBRA C, MED ARTS CENTER,66044
843-0677
53 F 3005 78 OBG
PRAEGER, MARK A, 1112 W SIXTH SUITE 204,66044
843-2010
42 M 1902 68 GS
REED, JAMES S, WATKINS MEMORIAL HOSP,66045
843-4455
23 M 1902 47 FP
REED, RALPH R, 404 MAINE,66044
842-3635
27 M 1902 53 IM
REESE, JOHN L, 346 MAINE,66044
842-6644
35 M 1902 61 GS
REITH, PAUL, 1331 NAISMITH,66044
843-4455
M 2834 IM
RIDROAN, TERRANCE, 346 MAINE,66044
842-4477
51 M 1902 77 AOL
ROBERTS, RICHARD S, 342 WOODLAWN DR,66044
-
19 M 2802 44 DO
SANDERS, J ALAN, LAWRENCE MEMORIAL HOSP,66044
842-2083
29 M 1902 60 PATH
SCHNOSE, GREGORY D, 1112 W SIXTH SUITE 210,66044
843-5160
51 M 1902 76 IM
SCHROEDER, SYDNEY D, 902 W 25TH,66044
841-4311
18 M 1902 44 P
SCHWEGLER, RAYMOND A, 1504 UNIVERSITY DR,66044
-
07 M 2604 31 DO
SEGEBRECHT, STEPHEN L, 3012 OXFORD RD,66044
841-5217
55 M 1902 80 OTO
SOSINSKI, RICHARD F, 1112 W SIXTH,66044
843-5160
51 M 1902 76 IM
TUCKER, DONALD R, 1517 INDIAN WELLS CT,66044
354-5275
31 M 1902 57 IM
VERNON, MARY C, 500 ROCKLEDGE,66044
841-6540
52 F 1902 77 FP
WELL, MICHAEL A, 645 COUNTRY CLUB TERR,66044
749-0104
41 M 1606 67 U
WERTZBERGER, JOHN, PO BOX 127,66044
843-9125
36 M 1902 63 ORS
WERTZBERGER, KENNETH LYNN, 1112 W SIXTH BOX 127,66044
843-9125
47 M 1902 73 ORS
WILCOX SR, HOWARD L, MEDICAL ARTS CENTER,66044
843-0677
18 M 3520 44 OBG
WOLLMANN, MARTIN, 2615 ORCHARD LN,66044
843-4455
26 M 1902 57 IM

LEAVENWORTH—913
(Leavenworth County Society)

AL-BAGHAL, MOHAMMAD, 113 DELAWARE SUITE A,66048
651-2200
45 M 87501 72 U
ANWAR, M ZIA, 109 DELAWARE,66048
651-2977
39 M 11801 67 IM
ASHKAR, ADNAN A, 109 DELAWARE SUITE F,66048
682-6818
42 M 52801 73 OBG
BARRY, DAVID R, 500 EISENHOWER RD,66048
727-6000
42 M 1902 68 FP
BUESING, OLIVER R, 230 NINTH,66048
-
10 M 2501 32 GS
CENAC, MARK T, 500 EISENHOWER RD,66048
727-6000
27 M 401 49 GS
COMBS, PETER S, 419 ARCH ST,66048
682-0242
14 M 4101 41 IM
DE SOUZA, DERRICK J, 2201 S FOURTH,66048
651-6030
43 M 49501 66 GS
DECENA, IMMACULADA, PO BOX 1675 VAMC,66048
-
45 F 74810 68 EM
DUYSAK, SAMI, 520 6TH AVE,66048
682-6661
22 M 90201 47 IM
GERBER, HARRY A, 605 N SIXTH,66048
-
96 M 5606 30 FP
GRAHAM, KENNETH L, RTE 2 BOX 182AA,66048
727-6000
21 M 3840 45 GS
GRAHAM, THOMAS W, 500 EISENHOWER RD,66048
727-6000
26 M 3840 50 IM
GRATNY, LINDA L, RR 3 BOX 513,66048
-
51 F 1902 88
GRISOLIA, ANDRES, 424 WALNUT ST,66048
682-5400
27 M 84708 50 ORS
HAMMEKE, JOHN C, 3601 S 4TH ST TRAFFICWAY,66048
682-5201
27 M 401 61 OPH
JOHNSON, PAUL D, 520 SIXTH AVE,66048
582-6661
36 M 1902 61 FP
KAVI, NAGESH G, 1714 RIDGE RD,66048
682-2000
32 M 49509 58 IM
LIPOFF, JAY I, 410 S FOURTH,66048
682-6950
50 M 3519 75 IM
MCCOLLUM, WILLIAM B, 3601 S FOURTH,66048
682-6661
41 M 1902 66 TS
MERRITT, W HENRY, 44 WESTWOOD DR,66048
682-6661
14 M 702 39 GS
MILLS, VERNON A, 4510 S 4TH TRFWAY,66048
682-6661
51 M 1902 77 PD
PARKER, ROBERT W, 500 EISENHOWER RD,66048
727-6000
45 M 1902 71 FP

PRAY, CLAUDIA M, 529 DELAWARE, 66048
682-4771
52 F 1902 74 PD
RABE, MELVIN A, 600 S BROADWAY,66048
-
14 M 1902 37 OO
SNOW, DONALD L, MED ARTS BLDG,66048
682-1000
21 M 64901 54 OBG
STRUTZ, WILLIAM C, 68 WESTWOOD DR,66048
682-8868
08 M 5606 43 R
VOORHEES, CARROLL O, 520 SIXTH AVE,66048
682-6661
25 M 1902 52 FP
VOORHEES, GORDON S, 520 SIXTH AVE,66048
642-6661
12 M 1902 39 IM
WALTZ, CHARLES A, 520 SIXTH AVE,66048
682-6661
35 M 3840 62 TS
WASHBURN, MICHAEL E, 4516-B S 4TH TRAFFICWAY,66048
727-2322
47 M 4705 73 GS

LEBO—316
(Flint Hills Society)

HUNTER, KENNETH R, ,66856
256-2565
07 M 1902 39 FP

LENORA—913
(Northwest Kansas Society)

STEICHEN, EDWARD F, ,67645
-
05 M 1601 31 FP

LIBERAL—316
(Seward County Society)

ALLEN, RAY E, 2 PLAZA DR, 67901
624-5691
37 M 1902 64 IM
CAEDO, CARMELITA O, 2401 LILAC DR,67901
624-1651
41 F 74801 63 R
CAMPION, WOODROW M, 121 W THIRD,67901
624-2594
13 M 1902 39 IM
ESTRADA, EDMUNDO C, 1023 N KANSAS SUITE 3,67901
733-1331
43 M 74801 67 GS
ESTRADA, LINA, 1023 N KANSAS SUITE 3,67901
733-1331
43 F 74801 68 PD
GRIMES, I ROSS, 222 W 15TH,67901
624-1676
27 M 3901 54 TS
HARRIS, NORVAN O, PO BOX 1069,67901
624-3811
20 M 1902 44 DBG
HOLCOMB, WILLIAM M, 15 E 11TH,67901
624-2252
31 M 3901 56 GS
KNUDSEN, DENNIS L, 222 W 15TH, 67901
624-3811
M OBG
KOONS, JESS W, 1210 N WASHINGTON,67901
624-3841
27 M 1902 57 OPH
NEVINS, RICHARD L, PO BOX 1824,67901
624-0255
47 M 3901 73 FP
PROCHAZKA, OTTO F, BOX 1809,67901
-
12 M 1902 38 OO
RATHBUN, EDWIN O, 610 W 11TH,67901
624-1841
36 M 1902 62 FP
REESE, JACK D, 15 E 11TH,67901
624-6226
32 M 1902 57 FP
WADE, THEODORE E, 318 N LINCOLN,67901
354-5275
04 M 512 30 OO
ZAINALI, ASSADOLLAH, 601 LILAC DR,67901
624-1651
46 M 51701 72 R

LINDSBORG—913
(McPherson County Society)

FREDRICKSON, DUANE E, 121 W LINCOLN,67456
227-3371
39 M 1902 66 FP
FULLER, DERYL O, RR 2 BOX 6A,67456
-
25 M 1902 50 OO
MURFITT, MALCOLM C, 231 N MAIN,67456
227-2732
13 M 801 41 FP

LINN—316

HATESOHL, STANLEY M, PO BOX 187,66953
-
57 M 1902 84

LYNDON—913
(Franklin County Society)

STOUT, NILES M, ,66451
828-4521
16 M 1902 50 FP

LYONS—316
(Rice County Society)

GRIMES, JAMES T, 1221 W NOBLE,67554
257-5124
27 M 1902 53 FP
SIEMENS, RICHARD A, 1221 W NOBLE,67554
257-5124
30 M 1902 59 FP
TOBIAS, ROGER R, 1114 S GRAND,67554
278-2123
51 M 1902 76 FP
WOLF, CURTIS V, 1221 W NOBLE,67554
257-5124
37 M 1902 64 FP

MADISON—316
(Flint Hills Society)

BROWNING, WILLIAM R, 205 W MAIN,66860
437-2200
44 M 1902 73 FP
PARKER, WAYNE G, RR #1,66860
437-2907
27 M 1902 56 FP

MANHATTAN—913
(Riley County Society)

BAKER, RICHARD B, 2600 ANDERSON,66502
537-4200
42 M 4113 68 ORS
BALL, RALPH G, 215 S DELAWARE,66502
-
33 M 1902 27 OO
BAMBARA, JOHN F, PO BOX 128,66502
539-5363
46 M 1902 75 PATH
BARLOW, JOHN M, 1133 COLLEGE,66502
539-3504
45 M 1102 71 OTO
BASCOM, GEORGE S, 1133 COLLEGE,66502
539-5341
27 M 2401 52 GS
BOESE, KENNETH M, 1133 COLLEGE AVE,66502
776-4744
25 M 1902 56 FP
BROWN, ROBERT M, 1133 COLLEGE,66502
537-4940
31 M 1902 63 FP
BURDICK, BRUCE M, PO BOX 743 FIELDSON,66502
776-9411
25 M 512 53 P

CATHEY, RD8ERT H, 1133 CDLLEGE AVE,66502
537-4990
42 M 1902 68 O
CRANE, CHARLES H, 1133 CDLLEGE,66502
537-9030
22 M 3520 46 PD
DDERRY, KAREN E, 2235 TAMARRON TERR,66502
-
58 F 1902 88
DURKEE, WILLIAM R, 1133 CDLLEGE AVE,66502
776-4744
23 M 1902 45 IM
FAIRCHILD, JOHN A, 756 CDLLEGE HTS CIR,66502
-
14 M 3006 41 DO
FISCHER, REX R, 1133 COLLEGE,66502
776-1400
34 M 3005 60 O8G
FREEMAN, FRED A, MANHATTAN MED CENTER,66502
537-8710
42 M 1902 69 U
GARDNER, JAMES D, 1133 COLLEGE AVE,66502
537-4940
43 M 2834 71 IM
HANCOCK, DANIEL E, 1133 CDLLEGE PD 8DX 128,66502
539-5363
45 M 2803 PATH
HAUN, RUDY T, 1133 CDLLEGE,66502
537-3888
49 M 1902 78 O8G
HEASTY, RD8ERT G, 2030 SCHEU DR,66502
-
11 M 3519 38 DO
HINKIN, DDUGLAS P, 2900 AMHERST,66502
776-9761
53 M 1902 78 FP
HDSTETTER, PHILIP H, 821 POYNTZ,66502
537-2544
17 M 1902 42 FP

JONES, WILLIAM T, 2600 ANDERSON, 66502
537-4200
50 M 1902 75 ORS

JUBELT, HILBERT P, 426 WESTVIEW DR,66502
-
19 M 1611 43 OO
KALDOR, RICHARD H, PD 8DX 128,66502
539-5363
40 M 2401 66 PATH
KIRK, THOMAS E, 1133 COLLEGE,66502
776-3451
44 M 3005 71 DPH
KLINGLER JR, EUGENE A, 1133 CDLLEGE,66502
539-5341
35 M 1902 62 GS
KLD8ASA, CHARLES L, 217 SDUTHWIND PLACE,66502
539-5337
49 M 2803 75 CHP
LAFENE, 8ENJAMIN W, 1844 ANDERSDN AVE,66502
-
01 M 3806 31 OD
LOWE, STANLEY W, 1133 COLLEGE AVE,66502
776-3451
32 M 1902 59 OPH
LYDNS JR, FRANK C, 1133 CDLLEGE AVE,66502
539-7641
44 M 3840 70 OR
MARSHALL, RONALD L, 1133 CDLLEGE AVE,66502
539-5322
42 M 3005 67 O8G
MARTIN, DANIEL C, LAFENE HEALTH CENTER KSU,66506
532-6544
30 M 1902 58 IM
MCKNIGHT, DAVID E, 1133 CDLLEGE AVE,66502
539-7641
32 M 1902 62 R
MCNEIL, ELBERT D, 1133 CDLLEGE,66502
537-9030
22 M 702 48 PD
MEEK, PALMER F, 1133 COLLEGE,66502
537-2651
45 M 1902 71 IM
MILLER, A8RAHAM H, 1133 CDLLEGE,66502
527-2651
29 M 4101 54 IM
MDSIER, MICHAEL L, 2900 AMHERST AVE,66502
776-9761
52 M 1902 77 FP
MDSIER, STEVEN J, 2900 AMHERST AVE,66502
776-9761
49 M 1902 74 FP
MDWRY, GERALD L, 1133 CDLLEGE,66502
776-1400
26 M 1902 53 O8G

OLNEY, RO8ERT O, 1133 COLLEGE AVE,66502
539-7555
27 M 3005 51 GS
PETERSDN, JACK T, 1133 COLLEGE,66502
539-5363
25 M 1902 50 PATH
PHILIPP, JDSEPH THEDDORE, 1133 COLLEGE 8LDG O,66502
537-7373
45 M 1902 67 OPH
REITZ, LELAND C, 1133 COLLEGE,66502
537-2651
36 M 1902 63 IM
REITZ, RDGER P, 1133 CDLLEGE,66502
537-2651
32 M 1902 59 IM
RDSE, GRAHAM C, 1133 CDLLEGE,66502
537-9030
45 M 4706 70 PD
SHIELDS, THOMAS M, 1133 COLLEGE,66502
539-5341
49 M 1902 74 GPVS
SNYDER, KELVIN K, 1133 COLLEGE,66502
537-9030
52 M 1902 80 PD
STONE, G REX, ROUTE 1 8DX 182,66502
-
29 M 1902 54 OO
TAYLDR, 8AR8ARA D, 1133 CDLLEGE,66502
357-4940
50 F 1902 75 IM
TIEMANN, WIL_IAM H, 1133 CDLLEGE,66502
537-4940
42 M 3005 67 FP
TOUT, RO8ERT C, LAFENE STUDENT HLTH CTR,66506
532-6544
27 M 4812 53 FP
VDLKMANN II, HARLEY W, 1133 COLLEGE AVE,66502
539-7641
47 M 1902 72 R
WALL, KEVIN K, 2900 AMHERST,66502
776-9761
53 M 2101 79 FP
WHITE, THADDEUS H, 1735 ANDERSDN AVE,66502
-
15 M 1902 42 OD

MANKATO—913
(Republic County Society)

KIM8ALL, RICHARD R, 102 S CENTER,66956
378-3511
45 M 1001 72 FP

MAPLE HILL — 913
(Flint Hills Society)

KEITH, RD8ERT MARSHALL, RURAL ROUTE 1,66507
-
27 M 801 54 P

MARYSVILLE—913
(Northeast Kansas Society)

ARGO, DDNALD A, 808 N 19TH,66508
562-2303
36 M 3005 64 FP
LAWS, LEWIS R, 808 N 19TH,66508
562-2303
25 M 1902 54 FP
RICHARDSON, CURTIS J, 805 N 10TH,66508
-
62 M 1902 88

MAYETTA — 913
(Shawnee County Society)

8EATY, JAMES R, RT 2 8DX 11,66509
295-8090
32 M 5101 66 EM

McLOUTH—913
(Shawnee County Society)

SNOOK, RDBERT RUFUS, ,66054
796-6116
11 M 1902 42 FP

McPHERSON—316
(McPherson County Society)

BILLINGS, THOMAS, PO BOX 1327,67460
241-5500
39 M 1902 66 FP
BRANDSTED, ERNEST C, 400 W 4TH,67460
241-1654
18 M 1606 44 DBG
CLAASSEN, SAMUEL D, 400 W FOURTH,67460
241-7033
53 M 1902 78 IM
COLLIER, WILLIAM J, 400 W 4TH,67460
241-1766
25 M 3605 49 TS
DENNIS, DAVID T, 400 W FOURTH,67460
-
53 M 1902 75 IM
DYCK, ARTHUR H, C/O PEOPLES BANK/TRUST,67460
241-0357
03 M 1902 28 FP
FERREE, RICHARD ALLAN, 400 W FOURTH,67460
241-7400
51 M 3006 76 FP
FIELDS, GALEN W, 333 C - S LAKESIDE DR,67460
-
15 M 1902 49 OD
JOHNSON, J RICHARD, 400 W 4TH,67460
241-4293
28 M 1902 55 IM
PIERSON, WEIR, BOX 1028,67460
241-1445
17 M 1902 44 FP
PRICE, VAUGHAN C, PO BOX 451,67460
-
05 M 4706 29 GS
SCHURLE, DALE R, 400 W FOURTH,67460
241-7033
53 M 1902 78 IM
THOMAS, GREGORY MCQUEEN, 400 W FOURTH,67460
241-7400
47 M 1902 73 FP

MEADE—316
(Iroquois County Society)

FELDMEYER, SEELEY T, PO BOX 1030,67864
873-5432
46 M 74811 80 GP
HILL, RICHARD H, 234 EAST CARTHAGE,67864
873-2113
18 M 1902 44 FP

MEDICINE LODGE—316
(Tri-County Society)

HOFFER, JOHN G, 910 N WALNUT,67104
886-3222
13 M 1902 44 GS
STUCKY, DEAN E, 901 N WALNUT,67104
886-5653
33 M 1902 60 FP

MINNEAPOLIS—913
(Saline County Society)

BARKER, STEVEN E, 311 N MILL,67467
392-2144
51 M 1902 76 FP
WEDEL, KENNETH O, 311 N MILL ST,67467
392-2144
32 M 1902 60 FP
WEDEL, KERMIT G, 311 N MILL ST,67467
392-2144
32 M 1902 60 FP

MINNEOLA—316
(Iroquois County Society)

STEPHENS, CHARLES, MINNEOLA CLINIC,67865
885-4202
33 M 2803 58 FP

MOUNDRIDGE — 316
(McPherson County Society)

KAUFMAN, WILLARD E, PO BOX 640,67107
345-6322
28 M 1902 53 FP
LOGANBILL, VARDEN J, PO BOX 640,67107
345-6322
26 M 1902 54 FP

MULVANE—316
(Sedgwick County Society)

COBB, LESLIE H, 102 E MAIN,67110
777-0101
17 M 4804 47 FP
TURKLE, JANET K, 506 RIVERDALE,67110
-
58 F 1902 86

NEODESHA—316
(Southeast Kansas Society)

CHRONISTER, BERT, PO BOX 118,66757
325-2622
38 M 1902 64 FP
MOORHEAD JR, F ALLEN, 709 MAIN ST,66757
325-2200
39 M 1902 65 FP

NESS CITY—913
(Central Kansas Society)

PRAKALAPAKORN, DARANEE, 412 N TOPEKA,67560
798-2233
47 F 89101 69 PD
PRAKALAPAKORN, YANYONG, 412 N TOPEKA,67560
798-2233
43 M 89101 69 GS

NEWTON—316
(Harvey County Society)

ALLEN, FRANCES A, 1112 BOYD,67114
-
15 F 1902 43 OD
BATES, MICHAEL NICHOLS, 215 S PINE SUITE 302,67114
283-4153
50 M 1902 75 DBG
BENTON, JAY S, 301 MAIN,67114
283-7257
23 M 4804 49 DBG
BOLT, MICHAEL, AXTELL CLINIC,67114
283-2800
51 M 1902 76 GS
CAMPBELL, FRANCES S, PO BOX 467,67114
283-2400
35 F 4101 61 P
CARPER, IVAN H, 203 E BROADWAY,67114
283-2800
28 M 1902 59 GS
CARPER, OWEN E, AXTELL CLINIC,67114
283-2800
37 M 1902 64 FP
CLAASSEN, MILTON A, 201 S PINE ST,67114
283-3600
32 M 1902 58 ORS
CRAIG, CHARLES C, AXTELL CLINIC,67114
283-2800
45 M 1902 71 ORS
DYCK, GEORGE, PRAIRIE VIEW INC,67114
283-2400
37 M 6201 64 P

ENNS, EUGENE K, 6 INDIAN LANE,67114
-
15 M 1902 40 00
FENT, LEE S, 316 OAK,67114
283-0505
14 M 2834 43 GS
FRANSEN, HERBERT, 215 S PINE SUITE 102,67114
283-0033
32 M 6501 60 GS
FRANSEN, PAUL H, 209 S PINE,67114
283-5040
46 M 6501 71 FP
GLOVER, RICHARD M, AXTELL CLINIC,67114
283-2800
21 M 1902 53 FP
GRABER, CHARLES, 215 S PINE STE 102, 67114
283-0033
44 M 3006 75 GS
GRISWOLD, DALE G, AXTELL CLINIC,67114
283-2800
27 M 1902 53 IM
HENDRICKSON, JON R, AXTELL CLINIC,67114
283-2800
51 M 1902 73 PD
HENDRICKSON, KATHRYN D, AXTELL CLINIC,67114
283-2800
52 F 1902 77 PD
HWA, EUGENE C, 500 MAIN,67114
283-1160
21 M 24216 47 R
IRWIN, RICHARD L, 218 S KANSAS AVE,67114
283-1400
48 M 1902 75 OPH
ISAAC, CHARLES A, 203 E BROADWAY,67114
283-2800
25 M 1902 49 U
KLIEWER, VERNON L, PO BOX 467,67114
283-2400
31 M 1606 57 CP
KUMAR, SURINDER, 201 S PINE,67114
283-3600
46 M 1902 69 OBG
LINDHOLM, GERALD R, AXTELL CLINIC,67114
283-2800
51 M 1902 76 FP
NACHTIGALL, ANDREW, BETHEL CLINIC,67114
283-3600
28 M 1902 59 PD
NIGHTENGALE, DIANE J, 1616 BERRY,67114
-
60 F 1902 86
OLSON, ERWIN T, BETHEL CLINIC,67114
283-3600
19 M 1902 47 PD
PRENTISS, HAROLD, 1305 TERRACE DR,67114
283-9433
36 M 1720 62 R
QAMAR, YUSUF, 203 E BROADWAY,67114
283-2800
38 M 70409 62 IM
RADOVANOV, RADMILA, BOX 364,67114
-
34 F 95702 60 R

RICH, ELDON S, PO BOX 277,67117
-
16 M 1902 46 OO
SCHMIDT, HERBERT P, CEDAR VILLAGE,67114
-
03 M 1902 34 OO
SILLS, CHARLES T, 1631 HILLCREST,67114
-
09 M 1902 37 OO
SIMMONS, ROBERT EARLE, 209 S PINE,67114
283-5040
49 M 1902 74 IM
TANDOC JR, VALENTIN T, BETHEL CLINIC,67114
283-3600
39 M 74809 62 U
TOMPKINS, CARL O, 316 OAK STREET,67114
283-1380
22 M 1902 51 FP
VOGT, VERNON W, BETHEL CLINIC,67114
283-3600
22 M 3005 53 FP
WHEELER, DWIGHT E, BETHEL CLINIC,67114
283-3600
50 M 2012 76 IM
WIENS, J WENDELL, 201 S PINE,67114
283-3600
32 M 1902 59 GS
WIENS, TIMOTHY K, 510 SE 2ND ST,67114
283-3504
55 M 1902

NORTON—913
(Northwest Kansas Society)

COLIP, F MERLYNN, 711 N NORTON,67654
877-3305
35 M 1902 61 FP
COOPER, ARTHUR E, 305 W WILBERFORCE,67654
-
08 M 1611 34 GP
HARTLEY, ROY WILEY, 711 N NORTON, 67654
877-3305
37 M 1902 63 FP
HARTMAN, ROGER L, 711 N NORTON,67654
877-3305
35 M 1902 61 FP
LONG, ROBERT C, 711 N NORTON,67654
927-3305
27 M 1902 53 GS
MEYER, JACK R, 711 N NORTON,67654
877-3305
51 M 1902 76 FP

NORTONVILLE—913
(Shawnee County Society)

MADISON, WILLARD A, ,66060
886-2110
20 M 1902 51 FP

OAKLEY—913
(Northwest Kansas Society)

OHMART, RICHARD V, PO BOX 756,67748
672-3262
36 M 1902 62 FP
SEKAVEC, GORDON B, 209 CENTER AVE,67748
672-3351
07 M 1902 38 FP

OBERLIN—913
(Northwest Kansas Society)

FOGLEMAN, MILLARD L, 902 W COLUMBIA,67749
475-2221
55 M 1902 80 FP
PALMER, MARGUERITE L, BOX 110,67749
475-2221
25 F 5404 54 GP
SIMPSON, ROBERT LIMBAUGH, 902 W COLUMBIA,67749
475-2221
25 M 4706 51 GS
WHITAKER, REN R, 902 W. COLUMBIA, 67749
475-2222
37 M 5404 66 FP

OLATHE—913
(Johnson County Society)

ARONOFF, MICHAEL E, 407 S CLAIRBORNE STE 209,66062
782-3953
39 M 1604 64 ENT
ASBURY, LAWRENCE J, OLATHE COMMUNITY HOSP,66062
782-1451
45 M 2878 77 EM
BEEBE, EDMER, 420 EAST CEDAR,66061
-
03 M 5605 32 FP
BLISS, JOY V, 42 HOLLY DRIVE,66062
791-4220
42 F 3005 68 ANES
BLUM, MICHAEL A, D.O., 401 S CLAIRBORNE,66062
764-7060
47 M 2878 73 PD
BROWN, PAUL W, 407 S CLAIRBORNE STE 104,66062
782-7515
44 M 1902 70 FP
CONANT, FERRILL R, 21325 W 180TH,66062
-
56 M 1902 86
DELPHIA, ROBERT E, 401 S CLAIRBORNE,66062
782-1610
24 M 1902 56 FP
ELIOT, DAVID W, 407 S CLAIRBORNE,66062
782-8487
44 M 2501 70 FP
ELDT, LAURENCE A, 407 SOUTH CLAIRBORNE,66062
782-8487
44 M 1902 71 FP

EISENHUT, RANDY E, 17 VENTURA,66061
-
61 M 1902 88
FAILING, TRENT L, 527 PERSIMMON DR,66061
-
55 M 1902 87
FORTUNE, CEDRIC B, PO BOX 910,66061
782-3322
40 M 1902 66 FP
GLAZZARD, CHARLES D, 555 E SANTA FE,66061
782-7000
28 M 2507 56 ?
HALVORSON, HOWARD C, 407 S CLAIRBORNE,66062
782-2020
41 M 5404 66 U
HUDSON, ROBERT P, 12925 FRONTIER RD,66061
588-7040
26 M 1902 52 IM
JENSEN, THOMAS M, 407 S CLAIRBORNE,66062
782-1148
47 M 3005 73 ORS
KARLIN, RONALD J, 15129 S BLACKFEATHER,66062
791-4357
54 M 1902 79 EM
LAIRD, DALE O, ONE PATRONS PLAZA,66061
782-3631
42 M 1902 68 OPH
MATHEWS, ROBERT C, OLATHE COMMUNITY HOSP,66061
791-4357
50 M 2834 77 EM
MATTHEW, WILLIAM L, PO BOX 910,66061
782-3322
29 M 1902 56 FP
MCCANN, WILLIAM E, PO BOX 8,66061
782-0262
22 M 3901 48 FP
MEE, ADRIAN W, 28 HOLLY DRIVE,66062
791-4220
19 M 1902 54 ANES
MELENDRES, JUANITO M, 7400 GLEASON RD - RR 1,66061
684-4649
36 M 74809 61 PD
MENDLICK, R MICHAEL, 407 S CLAIRBORNE STE 101,66062
782-1148
44 M 1902 70 ORS
MORGAN II, DAVID LLOYD, 807 S CLAIRBONRE,66062
782-8300
49 M 2820 77 IM
NOTTINGHAM, ROBERT M, 401 CLAIRBORNE,66062
782-1610
49 M 1902 78 FP
OYLER, JONATHAN M, 1706 PENROSE,66062
-
59 M 1902 87
PIERRON, GEORGE J, 540 EAST SANTA FE,66061
782-0260
22 M 1902 47 FP
ROMONDO, STEVEN A, OLATHE COMMUNITY HOSP,66061
791-4220
47 M 1902 73 ANES
RUHLEN, JAMES L, 807 S CLAIRBORNE,66062
782-8300
46 M 1902 72 IM
SEAMAN, LAUREN I, 1613 E SHERIDAN,66062
-
07 M 6001 38 FP
SETTLE JR, RUSSELL D, 407 S CLAIRBORNE,66062
782-3384
35 M 1902 60 P
SHANKER, STUART G, 401 S CLAIRBORNE STE 200,66062
764-7060
49 M 2803 75 PD
SHEFFER, KEITH D, 407 S CLAIRBORNE STE 101,66062
782-1148
37 M 1720 67 ORS
SNYDER, RICHARD HENRY, OLATHE COMMUNITY HOSP,66061
791-4220
45 M 1902 73 ANES
THOMPSON, SCOTT W, 15204 W 122ND,66062
782-3322
51 M 64914 78 FP
YEOMANS, RONALD N, 405 S CLAIRBORNE SUITE 4,66062
782-3073
40 M 1902 67 OBG

ONAGA—913
(Pottawatomie County Society)

ENGELKEN, SUSAN F, 711 LUCIEN PO BOX 300,66521
889-4242
49 F 3401 79 GP

FLECKENSTEIN, CHARLES S, 501 LUCIEN ST,66521
-
07 M 1902 36 OO
WALSH, THOMAS E, ONAGA CLINIC,66521
889-4241
48 M 1902 74 FP

OSAGE CITY—913
(Flint Hills Society)

ADAMS, DWIGHT, 608 HOLLIDAY,66523
528-3161
M 1902 GP
WILLIAMS, HOMER J, 611 S SIXTH,66523
-
05 M 1902 31 FP

OSAWATOMIE—913
(Miami County Society)

APPENFELLER, WILLIAM D, 524 BROWN AVE,66064
755-3166
25 M 1902 53 FP
BOSSEMEYER II, CHARLES H, 319 EASTGATE,66064
755-3044
49 M 1902 78 FP

OSWEGO—316
(Labette County Society)

BURGESS, ARTHUR P, 504 5TH STREET,67356
795-4427
19 M 1902 52 FP

OTTAWA—913
(Franklin County Society)

BLAKELEY, SHARON L, 1004 WILLOW,66067
-
62 F 1902 88
BLANKENSHIP, JIM D, 1320 S ASH,66067
242-5581
50 M 2834 76 FP
CORDER, S SCOTT, 1502 S CEDAR,66067
242-2641
51 M 1902 76 FP
GOLLIER II, ROBERT A, 1320 S ASH,66067
242-1620
40 M 1902 66 FP
HADLEY, DELMONT C, 1320 SOUTH ASH,66067
242-3891
35 M 1902 64 FP
HENNING, CALVIN W, 1502 CEDAR,66067
-
05 M 1902 35 FP
LAURY, DAVID G, 1320 S ASH,66067
242-1620
17 M 1606 44 FP
PHILGREEN, DONALD E, 1320 S ASH,66067
242-3891
39 M 1602 67 FP
RANSOM, WILLARD B, 1320 S ASH,66067
242-1620
49 M 1902 77 FP
REYES JR, FRANCISCO A, 1320 S ASH,66067
242-5312
38 M 74801 61 GS
SPEER, LOUIS N, PO BOX D,66067
242-1257
14 M 1606 41 FP
STREHLOW, CHESTER H, PROFESSIONAL PLAZA BLDG,66067
242-3891
30 M 1902 57 FP

OVERBROOK—913
(Shawnee County Society)

RUBLE JR, JAMES L, OVERBROOK COMM CLINIC,66524
665-2205
26 M 1902 53 FP

PAOLA—913
(Miami County Society)

BANKS, ROBERT E, PO BOX 298,66071
294-2305
29 M 1902 55 FP
ROWLETT, JACK G, PO DRAWER A,66071
294-2356
21 M 1902 52 FP
SCROGGIE, DANIEL J, BOX 158,66071
-
59 M 1902 88
STANLEY, REX C, PO DRAWER A,66071
294-2056
24 M 1902 52 GS

PARSONS—316
(Labette County Society)

AVES, AGNES, 1509 MAIN,67357
421-0600
38 F 74801 59 IM
AVES, RENATO B, 1509 MAIN STREET,67357
421-0600
35 M 74801 59 GS
CAREY, LARRY J, LABETTE CO MED CL SUITE 5,67357
421-8361
51 M 1902 74 FP
CRAMER, GUY W, 412 MURDOCK,67357
-
11 M 1902 39 OO
DAIZ, ANTONIO S, 1609 WASHINGTON,67357
421-0091
37 M 74810 63 OR
DILLON, WILLIAM L, LABETTE CO MED CL BOX H,67357
421-0881
45 M 1902 71 ORS
HENDERSON, CHARLES F, 207 CRESTVIEW,67357
-
14 M 1902 40 OO
KISHORE, ROY N, PO BOX 238,67357
421-4062
44 M 49511 66 OTO
KISHORE, SHEELA, 2907 JOHNSON RD,67357
421-2741
43 F 49511 66 ANES
LAVA, CHIRUND, PO BOX 290,67357
421-6210
40 M 89102 63 GS
MARTIN, EARL A, 1516 GRAND,67357
-
07 M 1606 35 OO
MILLER, CHARLES H, 2819 CLARK,67357
-
07 M 3006 32 OO
MILLER, DEAN M, 203 CRESTVIEW,67357
421-4880
22 M 1902 48 R
MILLER, STEPHEN FRANCIS, 1509 MAIN,67357
421-0600
45 M 1902 70 GS
PACE, JOHN D, KATY HOSPITAL CLINIC,67357
-
94 M 1902 20 FP
PAI, RADHA V, PO BOX 1057,67357
421-0080
45 F 6701 ANES
PAI, VARADARAJ S, PO BOX 1057,67357
421-0080
42 M 6701 U
PARANJOTHI, SUBRAMONIAM P, 1509 MAIN,67357
421-6160
39 M 49531 64 IM
PAULS, DANIEL N, PO BOX 1014,67357
421-1431
45 M 1902 71 IM
ROTHSTEIN, TERRY B, 220 NORTH 32ND,67357
421-5900
43 M 1606 69 OPH
SHARMA, ARUN L, 1509 MAIN,67357
421-0600
46 F 49503 69 FP
TANG, CHANTRA, PO BOX 1054,67357
421-2460
47 F 89104 71 PD
TANG, SAROHO, PO BOX 1054,67357
421-2460
43 M 89102 69 OBG
VERMA, ASHA, 400 KATY,67357
421-9090
37 F 49530 63 PD
VICHYANOND, PAKIT, LABETTE CO MEDICAL CENTER,67357
421-2460
58 M 89101 75 PD

PITTSBURG—316
(Crawford County Society)

ARMSTRONG, HAROLD J, PROFESSIONAL BUILDING,66762
232-2600
40 M 1902 68 ORS
BENA, JAMES H, 405 WEBSTER,66762
-
12 M 3005 36 OO
BERKEY, VERNON A, NATL BANK BLDG,66762
231-7650
18 M 1902 43 R
BIERLEIN, KENNETH J, 812 S CATALPA,66762
-
06 M 1606 33 OO
COOMER, TYLER E, 315 NATL BANK BLDG,66762
231-7730
30 M 2101 59 GS
COOPER, KENT J, 909 CENTENNIAL,66762
231-6280
41 M 1902 73 FP
ESCH, JOHN G, 613 N BROADWAY SUITE E,66762
231-5360
24 M 3006 48 GS
FREEMAN, MALCOLM C, 1102 VILLAGE DR,66762
231-6100
44 M 35207 68 ANES
GOMETZ, MODESTO S, 909 E CENTENNIAL #6,66762
231-2490
35 M 72601 63 PD
HOLSINGER, DONALD M, 1015 MT CARMEL PL,66762
231-5900
38 M 1902 64 IM
HUEBNER, ROBERT STEPHAN, NATIONAL BANK BLDG,66762
231-6160
42 M 1606 67 GS
HUERTER, DAVID F, 909 CENTENNIAL,66762
231-1650
46 M 1902 72 IM
LANCE, RAYMOND W, 608 W QUINCY,66762
-
22 M 1902 47 OO
LEFFLER, PAUL B, 309 WINWOOD,66762
-
02 M 1902 40 OO
MILLER, EARL E, 1312 S BROADWAY,66762
231-6410
13 M 1902 37 ENT
MULLER, SAMUEL B, 611 W QUINCY,66762
-
05 M 1902 34 OO
NEWMAN, CLIFFORD B, 1204 E 7TH,66762
-
01 M 1902 28 OO
OOGERS, ROONEY K, 909 CENTENNIAL,66762
231-4300
M 1902 74 IM
PAPP JR, S DEAN, R 5 BOX 293,66762
231-7650
46 M 1902 72 OR
PARSI, MANUTCHEHR K, 909 CENTENNIAL,66762
231-3770
38 M 51701 64 OBG
POGSON, GEORGE W, 1015 MT CARMEL PLACE,66762
231-5900
24 M 1902 47 IM
RAMIREZ, AUGUSTO H, 909 CENTENNIAL,66762
231-1600
32 M 26407 58 IM
RAMIREZ, IRENE, 909 CENTENNIAL,66762
231-6280
F PD
SCHLEMMER, ROGER B, 1009 S BROADWAY,66762
231-6380
37 M 1902 68 OPH
SEGLIE, FLOYD RONALD, 909 CENTENNIAL DR SUITE 3,66762
231-6280
43 M 1902 69 FP
TAWIL, ELIAS ADIB, 2701 S ROUSE,66762
231-0850
52 M 33004 76 U
TWEET, FREDRICK A, RR 5 BOX 196,66762
231-6100
39 M 1602 66 PATH

WHITE, JOHN P, O.O., MT CARMEL MED CENTER,66762
232-2270
43 M 1875 72 P
YAGHMOUR, TALAAT E, 2701 S ROUSE,66762
231-0850
40 M 33002 64 U
ZABEL, KENNETH P, 909 CENTENNIAL,66762
231-1650
37 M 1902 65 IM

PLAINVILLE—913
(Central Kansas Society)

KELLERMAN, RICK, 409 S COCHRAN,67663
434-4609
M 1902 FP
PAGE, O VALE, 409 S COCHRAN ST,67663
434-4609
20 M 1902 51 FP
PEDERSON, ARNOLD M, 409 S COCHRAN,67663
434-4609
22 M 1902 51 FP

PLEASANTON—913
(Bourbon County Society)

JUSTUS, WILLIAM J, PO BOX 407,66075
352-6134
29 M 1902 55 FP

PRATT—316
(Ninnescah Society)

AMBLER, CARL O, 200 COMMODORE,67124
672-6476
31 M 1902 57 P
BARKER, PATRICK N, 420 COUNTRY CLUB RD,67124
672-7411
45 M 1902 71 GS
BLACK, CYRIL V, 223 E 4TH,67124
672-6403
05 M 4802 30 GS
DILLON, STEVEN C, 420 COUNTRY CLUB RD,67124
672-7411
53 M 1902 78 IM
FILLEY, VERNON W, PO BOX 1044,67124
672-5555
13 M 3005 43 GS
FREEMAN, F GILES, 310 E 2ND,67124
672-5555
18 M 1902 44 FP
MASON, ROGER, 420 COUNTRY CLUB RD,67124
672-2411
M
OUENZER, RONALD W, 420 COUNTRY CLUB RD,67124
672-7411
46 M 1601 73 IM
ROSEN, CARL H, 420 COUNTRY CLUB RD,67124
672-7411
46 M 4812 72 U
SIBALA, JUSTO L, 200 COMMODORE,67124
672-7159
20 M 74802 49 R
SUITER, DANIEL JAY, PO BOX 869,67124
672-7411
44 M 1902 71 GE
THORPE, FRANCIS A, 2 LAKE ROAD,67124
672-5555
08 M 1606 35 FP
WARD, ROBERT L, 1219G E FIRST,67124
672-6220
24 M 1902 52 FP
WOLFF, FREDERICK P, 223 E 4TH,67124
672-6403
20 M 1902 44 IM

PROTECTION—316
(Iroquois County Society)

GLENN, LYLE G, 146 BROADWAY BOX 447,67127
622-4686
12 M 1606 40 FP

QUINTER—913
(Northwest Kansas Society)

HIESTERMAN, HERMAN W, QUINTER CLINIC BLDG,67752
754-3333
23 M 1902 51 FP

RANSOM—913
(Central Kansas Society)

MCLAIN, KENNETH, BOX 247,67572
731-2295
21 M 1902 46 FP

RUSSELL—913
(Central Kansas Society)

MERKEL, EARL O, SHIELDS BLDG,67665
483-2178
32 M 1902 57 FP
PANICHABHONGSE, SAMBHUNOH, 213 WEST 7TH,67665
483-2133
43 M 89101 67 GS
PETTIJOHN, WALTER J, 624 W 12TH,67665
-
12 M 1902 37 OO
STARKEY, JERALD L, 326 MAIN,67665
483-2178
30 M 1902 56 FP
SWANN, CLAIR L, 112 W SIXTH,67665
483-4212
13 M 1902 39 IM
WHITE, FAGAN N, 356 W 5TH,67665
-
11 M 702 36 OO

SABETHA—913
(Northeast Kansas Society)

KENNALLY, KEVIN P, 1115 MAIN,66534
284-2141
53 M 1902 78 FP
KETTER, IVAN C, RTE 1,66534
-
60 M 1902 87
MONTGOMERY, THOMAS ALLEN, 1013 WYOMING,66534
-
10 M 1902 49 OO
WENGER, GREGG O, 1115 MAIN,66534
284-2141
M 1902 78 PO
YULICH, JOHN O, PO BOX 227,66534
284-2125
33 M 1902 59 FP

SALINA—913
(Saline County Society)

ALLEN, MONTE L, 600-E SOUTH SANTA FE,67401
827-0307
36 M 1902 61 OTO
ALSOP, WILLIAM R, PO BOX 260,67402
827-0260
52 M GE
ANDERSON, JODY, PO BOX 260,67402
827-0260
32 F 1902 59 IM
BAXTER, W REESE, P O BOX 1707,67401
825-8221
47 M 1902 73 FP
BELL, MARK G, 909 E WAYNE,67401
823-7225
50 M ENT
BROWN, ROBERT WAYNE, PO BOX 1747,67402
825-7251
23 M 1902 55 IM
BRUMMETT, RICHARD R, P O BOX 1707,67401
825-8221
34 M 1902 64 FP
BRUNGARDT, BERNARD A, 400 E BELOIT,67401
-
21 M 3006 46 OO
BUNDGARD, PETER A, 110 W RAY,67401
825-5786
54 M 1902 82 FP

BYERS, JONELL, PO BOX 260,67402
827-0260
53 FP
CATHCART-RAKE, WILLIAM F, 737 E CRAWFORD,67402
827-0260
48 M 1902 74 IM
CLARK, DAVID H, 617 E ELM,67401
825-8221
36 M 1902 62 FP
COFFEY, ROY B, 671 ELMORE DRIVE,67401
823-6397
24 M 1902 47 ORS
CONNELLY, MAURICE R, RR 3 BOX 44,67401
-
12 M 2002 38 OD
CONNER, BRIAN, 1518 B EAST IRON,67401
825-2272
46 M 1902 OPH
COSSETTE, JERROLD E, 909 E WAYNE,67401
823-7225
46 M 1902 75 ENT
COVERT, THOMAS J, PO BOX 260,67402
827-0260
M PD
CULTRON, FRANK T, 800 E CRAWFORD,67401
823-8151
10 M 1643 38 OPH
D'SOUZA, BISMARCK C, BOX 2318,67401
827-9526
45 M 49501 67 R
DOWELL, JAMES C, 645 E IRON,67402
827-7255
26 M 1611 49 IM
DRAEMEL, H RICHARD, 600-E SOUTH SANTA FE,67401
827-0307
18 M 1902 53 OTO
DREHER, HENRY S, PO BOX 260,67402
827-0260
18 M 1902 43 IM
EATON, GLEN E, RR 6 BOX 359,67401
827-3064
28 M 1902 54 ANES
EATON, LESLIE F, RR 1 BOX 346,67401
-
06 M 1902 32 OD
ELLISON, PAUL O, 1499 E IRON,67401
825-7271
35 M 2105 60 OPH
FEIGHNY, ROBERT E, 2437 VILLAGE,67401
-
20 M 1902 51 ORS
FORSTER JR, LOUIS G, BOX 1747 - 130 W CLAFLIN,67401
825-8221
47 M 1902 73 FP
FRANCIS, ANTHONY E, 519 S SANTA FE,67401
827-4424
54 M 1902 77 ORS
FREEMAN, RAYMOND S, 644 S OHIO BOX 2244,67402
823-6222
20 M 702 50 PD
GANS, FREDERICK A, 950 S ELEVENTH,67401
-
22 M 2834 46 OD
GRIFFING, RICHARD B, PO BOX 2606, 67402
827-3294
M 1902 53 ANES
GRIFFITH, FRANK H, 1493 E IRON,67401
827-0488
45 M 4813 75 OPH
GUNN, MARVIN R, BOX 2318,67401
827-9526
28 M 3901 54 R
GUZMAN, MANUEL, CKMHC,67401
823-6322
27 M 64901 54 P
HARBIN, GARY LYNN, 523 S SANTA FE,67401
823-7213
50 M 1902 75 ORS
HARRIS, NORMAN R, PO BOX 1845,67402
825-8191
30 M 1902 59 OBG
HASSLER, RANDY D, 645 E IRON,67401
827-9635
45 M 1902 71 U
HATTON, LLOYD W, 709 HIGHLAND,67401
-
06 M 1902 33 P
HERRMAN, ADAM L, 519 S SANTA FE,67401
827-4424
48 M 1902 74 ORS
HODGES, MERLE A, PO BOX 1845,67402
825-8191
34 M 1902 58 OBG

HOLMAN, JON B, PO BOX 61,67401
827-9366
33 M 1902 63 P
HUNNINGHAKE, ROVALD, 617 E ELM BOX 1707,67401
825-8221
51 M 1902 76 FP
JACKSON JR, OELMAS A, 645 E IRON,67402
827-7255
35 M 2101 60 IM
KREHBIEL, MARK A, 617 E ELM,67401
825-8221
49 M 1902 74 FP
KRUCKEMYER, ALAN L, 645 E IRON,67401
823-2215
45 M 1103 71 ORS
LAKE, MAX S, 124 S OAKDALE,67401
-
19 M 3005 43 OD
LASLEY, DAVID A, 645 E IRON,67401
-
22 M 1606 47 OD
LAWRENCE, GILBERT A, 116-A S SEVENTH,67401
827-9526
M R
LIVINGSTON, CHARLES E, 400 E IRON,67401
823-9166
32 M 1611 57 GS
LUNGSTRUM, JACK E, 645 E IRON,67401
823-2215
21 M 1902 59 ORS
MACY, NORMAN E, BOX 1285,67401
827-4053
35 M 1902 60 PATH
MACY, TED L, PO BOX 260,67402
827-0260
43 M 1902 71 GS
MARCHBANKS, DONALD L, 520 COUNTRY CLUB RD,67401
823-2380
24 M 1902 51 FP
MARSHALL, GEORGE W, PO BOX 1845,67402
225-3191
44 M 1902 70 OBG
MARTIN, OLIVER L, 715 E REPUBLIC,67401
827-9631
08 M 1902 37 OBG
MATTHEWS, EARL H, 135 E CLAFLIN,67401
827-9631
M 1902 GS
MAXWELL, GORDON E, 135 E CLAFLIN,67401
827-9631
29 M 1902 55 OBG
MCCRAE, SPENCER C, 655 GUERNSEY DR,67401
-
18 M 3509 43 OD
MILLER, ELDEN V, 1928 RIDGELEA,67401
827-3061
19 M 1902 44 ANES
MOWERY, WILLIAM E, PO BOX 260,67402
827-0260
23 M 1902 47 GS
NEUMANN, JAMES W, 600-E SOUTH SANTA FE,67401
825-5041
M N
NICKELL, WENDELL K, 400 E IRON,67401
823-9166
26 M 1606 50 TS
NIXON, RICHARD R, BOX 2318,67401
827-9526
32 M 1643 57 R
NULL, WILLIAM G, 135 E CLAFLIN,67401
827-9631
31 M 102 57 PD
OBANDO, GUILLERMO, 2110 KNOLLCREST DR, 67402
827-7261
35 M 26404 62 R
PALMER, GERALD K, PO BOX 1285,67401
823-7201
24 M 1803 53 PATH
PARKS, DOUGLAS S, 2158 KENSINGTON,67401
-
56 M 1902 83 FP
PETERSON, JAMES E, BOX 2318,67401
827-9526
53 M 1902 78 OR
REECE, RICHARD J, BOX 2318,67401
827-9526
23 M 1902 49 R
RICHARDS, JON F, 135 E CLAFLIN,67401
827-9631
50 M
RODERICK, JAMES E, 645 E IRON,67401
827-9635
23 M 1902 47 U

ROMEISER, REX S, 645 E IRON,67401
827-9635
41 M 1902 67 U
RUEB, ANDREW E, 11 CRESTVIEW DR,67401
827-6691
11 M 1606 35 GS
SCHMIDT, RAMDN WARNER, 400 E IRDN,67401
823-9166
39 M 1902 65 GS
SCOTT, CHESTER E, 519 S SANTA FE,67401
827-5549
23 M 1902 51 FP
SEATDN, RDBERT D, PD BOX 260,67402
827-0260
M NEP
SEBREE, STEVEN G, PD BOX 260,67401
827-0260
47 M 1902 73 DBG
SLOO, MILO G, 645 E IRDN,67401
823-2215
41 M 1902 67 DRS
SMITH, BDYD E, BDX 1285,67401
827-4053
46 M 3005 72 PATH
SMITH, DAVID E, PO BDX 260,67402
827-0260
50 M 1902 76 GS
SMITH, HAROLD R, PD BDX 260,67402
827-0260
19 M 1902 51 GS
SNYDER, THOMAS E, PD BDX 260,67402
827-0260
47 M 1902 DBG
STOSKDPF, LAWRENCE E, 2413 EDGEHILL,67401
823-9498
39 M 1902 72 ANES
STUEWE, BRADLEY R, PO BOX 260,67402
827-0260
49 M IM
TAYLDR, THOMAS F, 430 S DHIO,67401
827-0346
26 M 1902 53 FP
WAGENBLAST, HOWARD R, PO BOX 260, 67402
827-7261
21 M 1902 49 FP
WATERS, CLARENCE N, 530 S 5TH,67401
823-6497
13 M 2834 48 O
WEBER, ROBERT W, 645 E IRDN,67402
827-7255
26 M 1902 49 IM

SATANTA—316
(Southwest Kansas Society)

JABEL, JUVENAL T, SATANTA CLINIC,67870
649-2771
43 M 74809 IM
TADURAN, VIRGILIO, BDX 547,67870
649-2771
43 M 74810 43 PATH

SCOTT CITY—316
(Southwest Kansas Society)

DUNN, DANIEL R, 202 CDLLEGE,67871
872-2187
49 M 1902 74 FP
HDPKINS JR, B MORRISDN, 202 CDLLEGE,67871
872-2187
23 M 1902 53 FP

SEDAN—316
(Southeast Kansas Society)

TAYLDR, ELMER W, 120 WEST DSAGE,67361
725-3141
28 M 512 57 FP
WALKER, WILLIAM K, 111 E CHERDKEE,67361
725-3171
18 M 1902 45 FP

SEDGWICK—316

GATSCHET, TIMOTHY P, 314 CDMMERCIAL,67135
-
50 M 1902 85

SENECA—913
(Northeast Kansas Society)

BERKLEY, NORMAN W, 15 SOUTH 5TH ST,66538
336-2128
31 M 1902 63 FP
GILBERT, J HOWARD, 211 S FDURTH,66538
-
05 M 1902 41 OD
LUEGER, D.O., JAMES JOHN, 201 N 6TH, 66538
336-6113
51 M 2878 78

SHARON SPRINGS—913
(Northwest Kansas Society)

CHUNG, JOHN J, BOX 310,67758
852-4214
23 M 58301 48 FP

SHAWNEE MISSION—913
(Johnson County Society)

ALLEN, MAX S, 5103 W 96TH TERR,66207
588-6063
11 M 1902 37 IM
ALTENBERND, ELVIN CONRAD, 7319 W 81ST,66204
648-2010
26 M 1902 54 FP
ANDERSDN, WILLIAM A, 2508 W 71ST,66208
236-7288
50 M 2846 76 EM
ARMBRUSTER, ALBERT A, 9119 WEST 74TH SUITE 202,66204
362-9220
17 M 512 55 GS
ATHDN, MERRILL D, 6806 W 83RD,66204
642-4242
24 M 1902 54 FP
ATKINS, JEFFREY A, 6648 CHARLES,66216
-
61 M 1902 87
BADEEN II, LOUIS JDHN, 10550 QUIVIRA RD,66215
492-3344
49 M 2846 74 DPH
BAEKE, JOHN O, 6806 W 83RD, 66204
642-4242
19 M 1902 52 FP
BAKER, WILLIAM STEVEN, 7700 W 63RD,66202
262-1843
47 M 702 73 P
BALANOFF, ARNOLD Z, 4601 W 109TH SUITE 122,66211
642-4040
42 M 1803 67 PD
BANSAL, RDDPA D, 5600 W 95TH SUITE 105,66207
384-2220
37 F 49504 64 FP
BANSAL, SATISH C, 8901 W 74TH SUITE 147,66204
384-2220
38 M 49541 61 DRS
BAPTIST, JEREMY E, 5811 DUTLDDK,66202
432-0625
40 M 2846 78 A
BARE II, CHARLES E, 8901 W 74TH SUITE 353,66204
677-2460
43 M 1902 69 U
BARKER, ELIZABETH B, 4121 WEST 83RD SUITE 123,66208
381-6669
30 F 4706 55 P
BARKER, JAMES BERTDN, 8901 W 74TH,66204
362-6310
31 M 4706 55 DTD
BARNETT JR, THDMAS E, 10550 QUIVIRA SUITE 290,66215
492-2555
52 M 1902 75 IM
BARNHART, RDNALD J, 9119 WEST 74TH,66204
831-2334
41 M 2501 68 DBG
BARNHDRST, DONALD A, 10550 QUIVIRA STE 510,66215
492-6200
37 M 2834 63 CDS
BARR, RICHARD N, 7301 MISSIDN RDAD,66208
432-4366
32 M 1902 57 DPH
BARRICK, BRUCE, SH MISSIDN MEDICAL CENTER,66201
676-2340
39 M 1902 65 PATH
BATTY, LARRY H, 9119 W 74TH,66204
831-2334
51 M 1902 77 DBG
BATTY, THOMAS V, 5555 W 58TH,66202
432-2080
21 M 3806 54 FP

BAUER, JOSEPH G. 9640 CATALINA,66207
-
59 M 1902 88
BAUER, LAFE W. 4818 W 80TH,66208
642-5369
20 M 1902 49 ANES
BAUER, MARTIN L. 2500 W 71ST,66205
281-8881
47 M 1902 73 PD
BECKER, BRYAN N. 6501 WENONGA,66208
-
62 M 1902 88
BEEZLEY, MICHAEL J. 8800 W 75TH SUITE 115,66204
262-9201
47 M 1902 73
BELDEN, MARY J. 5010-12 GLENWOOD,66202
262-4294
61 F 1902 87
BELL, DELORIS W. 4601 W 109TH SUITE 116,66211
491-6550
42 F 1902 68 OPH
BELT, ROBERT J. 8901 W 74TH SUITE 34,66204
362-3023
45 M 702 71 IM
BELZ, MICHAEL K. 9218 GODDARD,66214
-
61 M 1902 87
BELZER, EDWARD G. PO BOX 7426,66207
381-8282
36 M 3005 58 PD
BENSON, DAVID R. 7707 MOHAWK,66208
640-6899
51 M 1902 87
BERGER, WILLIAM. 8630 HALSEY, 66215
492-6600
54 M 1902 80 IM
BERRY, JOHN M. 8800 W 75TH SUITE 320,66204
262-3288
47 M 1902 74 D
BIKALES, VICTOR WILLIAM. 10688 RIGGS LANE,66212
383-1311
13 M 2105 38 P
BILLINGSLEY, THAD H. 7000 SQUIBB RD #100,66202
432-9900
41 M 1902 66 P
BISHOP, FRANCIS E. 7501 MISSION RD,66208
648-3533
20 M 1902 45 P
BISHOP, HENRY R. 10550 QUIVIRA SUITE 320,66215
492-3600
53 M 4813 79 OBG
BLETZ, DONALD B. 10550 QUIVIRA SUITE 510,66215
492-6200
28 M 5104 58 IM
BOLES, J MICHAEL. 5949 NIEMAN ROAD,66203
631-1300
35 M 1902 61 FP
BOTTS, LARRY D. 8901 W 74TH SUITE 348,66204
432-8000
52 M 3005 79 PUD
BRAVERMAN, DAVID ELLIOTT. 4601 W 109,66211
341-1101
47 M 2507 72 PDO
BROOKS, WILLIAM HENRY. 2213 W 49TH TERR,66205
371-4343
49 M 1902 74 R
BROUCEK, FRANCIS J. 4121 W 83RD,66208
642-6845
32 M 1643 58 P
BROWN, JEFFERY C. 8336 RUSSELL,66212
-
61 M 1902 88
BROWN, WILLIAM R. 7301 MISSION RD,66208
236-8866
23 M 1902 48 IM
BROXTERMAN, STEVEN JOSEPH. 8901 W 74TH SUITE 225,66204
362-5510
51 M 1902 76 FP
BRUNER JR, KENNETH W. 4505 W 64TH,66208
262-3286
44 M 2401 70 PATH
BRUNING, ROGER MARION. 7301 MISSION SUITE 342,66208
384-0745
48 M 1902 70 FP
BUCK JR, WILLIAM D. 10807 OASIS CT APT 113,66203
-
59 M 1902 86
BUCKMAN, MARTIN SPALDING. 10550 QUIVIRA SUITE 290,66215
492-2555
49 M 2802 76 IM
BUHR, BRUCE R. 9800 W 56TH,66203
-
51 M 1902 87
BURGER, PAUL B. 5638 NIEMAN RD,66203
631-6114
25 M 2834 50 FP

CALKINS, LARRY L. 5635 SUWANEE RD,66205
-
18 M 1902 43 OO
CAMARATA, PAUL J. 12000 W 66TH,66216
-
60 M 1902 86
CARRIAGA, MARISA T. BOX 8128,66208
-
56 F 1902 88
CASTEEL, CHARLES K. 8901 W 74TH SUITE 357,66204
831-1003
34 M 3901 59 U
CATTANEO, ERNEST A. 6100 MARTWAY,66202
262-3930
39 M 1902 65 IM
CAVITT, ROBERT F. 9119 WEST 74TH,66204
831-0700
24 M 1902 48 GS
CEDERLIND, CRANSTON JAY. 8901 W 74 SUITE 36,66204
236-6455
45 M 1902 71 OBG
CHALABI, PHILLIP M. 11814 W 66TH,66203
631-8443
61 M 1902 87
CHANG, SHU FANG. 10200 W 75TH,66204
432-7885
25 F 24239 49 P
CLENDENIN, ROBERT KEELE. BOX 25785,66225
341-2100
48 M 1902 73 EM
CLOYD, DAVID W. 8901 W 97TH TERR,66212
-
55 M 3005 80 GS
CLYMER, DAVID J. 2309 W 71ST TERR,66208
-
53 M 4705 80 ORS
COE, RICHARD D. 7301 MISSION RD SUITE 247,66208
362-8505
31 M 4804 56 OPH
COHEN, MARC D. 8800 W 75TH SUITE 300,66204
362-1226
51 M 1001 77 IM
COHEN, ROBERT A. 3700 W 83RD,66208
642-2100
39 M 2803 64 PD
COHN, L ELIZABETH. 9917 ROE BLVD,66103
-
62 F 1902 88
COHN, STEVEN G, 8627 LINDEN DR, 66207
334-2500
41 M 1902 67 ANES
COLEMAN, ROBERT L. 8901 W 74TH SUITE 1,66204
362-0100
41 M 4113 66 PS
COOLEY, DAVID A. 8800 W 75TH SUITE 300,66204
352-1226
40 M 2802 66 RHU
COONROD, SCOTT A, 9311 W 89TH TERRACE, 66212
--
62 M 1902 88
COOPER, JACK R. 5300 MISSION RD,66205
-
17 M 3840 43 OO
CORBIN, MURRAY D. 10550 QUIVIRA RD-5TH FL,66215
492-6200
39 M 1902 65 CD
COULTER, HENRY F. 4203 W 151 ST,66224
-
23 M 1902 51 OO
COULTER, THOMAS B. 8800 W 75TH SUITE 310,66204
677-3113
38 M 1205 64 OPH
COVINGTON, CHRISTOPHER G. 4824 W 76TH,66208
-
53 M 3901 80 NS
COX JR, IRA. 5829 WOODSON PO BOX 975,66201
722-1100
19 M 1902 49 FP
CREEK, ALAN D. D.O., 10550 QUIVIRA SUITE 430,66215
437-2200
46 M 2878 78 FP
CROW, JIMMIE R. 7312 ANTIOCH,66204
384-2850
53 M 1902 78 GS
CURRAN, KEVIN E. 4121 W 83RD,66208
649-9383
39 M 2803 65 OPH
DANIELS, PATRICIA W. 7016 ANTIOCH,66204
-
60 F 1902 88
DAVIS, BRADLEY E, 8214 W 101, 66212
--
60 M 1902 86
DAVIS, RICHARD E. 8340 MISSION RD #118,66207
-
26 M 1902 54 OO

DEAY, CHARLES J, 9230 W 73RD SUITE 107,66204
-
60 M 1902 86
DELP, MAHLON H, 6131 TERRYDALE RD,66202
-
03 M 1902 34 IM
DENISON, TERRY R, 5811 DUTLDDK,66202
432-0625
29 M 1902 56 PD
DERRINGTON, KENNETH L, FDX HILL MED BLDG,66211
491-6464
44 M 1902 71 FP
DDCKHDRN, RDBERT J, 5300 W 94TH TERR,66207
381-4674
34 M 1902 60 PDA
DDHERTY, WILLIAM R, 7600 STATE LINE,66208
649-3900
20 M 3006 56 FP
DOWNARD, JAMES M, 5011 LAMAR APT 3,66202
-
61 M 1902 88
DRAKE, CYNTHIA, 8901 W 74TH SUITE 248, 66204
384-4990
57 F 1902 81 OBG
DREILING, RDGER J, 8901 W 74TH SUITE 21,66204
722-0080
51 M 1902 78 CD
DUCKETT II, THOMAS G, 4601 W 109TH SUITE 116,66211
491-4322
41 M 1902 67 DPH
EDWARDS, KIMBERLY K, 7839 KESSLER LN,66204
-
62 F 1902 88
ELCOCK, DAVID G, 3518 W 83RD APT 212,66208
-
56 M 1902 88
ENDERS, WRAY, 9034 CDTTDNWDDD DR,66215
-
02 M 1902 36 ANES
ESRIG, HARDLD L, D.D., 8132 SAGAMDRE,66206
381-5033
30 M 2878 60 ANES
ETZENHDUSER III, RUSSELL D, P O BDX 7426,66207
381-8282
34 M 1902 59 PD
EVANS, CAROL ANN, 8901 W 74TH SUITE 228,66204
362-0000
54 F 2846 78 IM
EVANS JR, WILLIAM E, 8741 HIGH DRIVE,66206
362-7363
24 M 1902 58 FP
FERGUSON, RDBERT LEDN, 8901 W 74TH SUITE 208,66204
362-0300
47 M 1902 73 IM
FLUTY, STEVEN R, 6920 W 72ND,66204
-
59 M 1902 88
FDRDYCE, NDRMAN, 8901 W 74TH,66204
722-0020
41 M 1902 67 DTD
FRANCISCD, CLARENCE L, 3509 W 85TH,66206
371-6802
09 M 1902 34 DRS
FRANK-GEIER, MARY S, 6025 W 50TH,66202
-
53 F 1902 88
FRANKEL, SCDTT J, 4601 W 109TH SUITE 318,66211
383-3630
53 M 2802 79 A
GAGE, BETSE M, 9119 W 74TH SUITE 107,66204
384-5500
55 F 1902 80 PD
GALBUT, ALAN S, 6720 W 52ND PLACE APT 38,66202
-
55 M 3806 81 IM
GALLEHUGH, KEITH W, 9027 BIRCH,66207
371-4343
32 M 1902 57 R
GARCIA, FRANCISCD, 8020 SANTA FE,66204
642-5000
32 M 27501 60 FP
GARCIA-FERRER, CIRA M, 9409 W 82ND,66204
-
60 F 1902 87
GARDINER, ROBERT C, 6220 W 51ST APT 2,66202
-
57 M 1902 86
GARDNER, GLENN M, 5200 WEST 64TH,66208
-
35 M 2803 60 IM
GAUGHAN, MICHAEL J, 7312 ANTIDCH SUITE 150,66204
677-0883
49 M 1902 74 R

GEIER, DAVID L, 10812 HAUSER,66210
-
62 M 1902 88
GENTRY, KALE C, 5105 W 84TH,66207
632-4242
31 M 1902 60 FP
GERRDND, LINDA L, 5201 HDWE DR,66205
-
53 F 1902 86
GILBERT, RDBERTA M, 4121 W 83RD,66208
649-5566
35 F 3506 62 P
GILLEN, BILLY A, 8802 BIRCH LANE,66207
-
29 M 1902 54 ANES
GDLDSTEIN, GERALD L, 4601 W 109TH SUITE 318,66211
383-3630
47 M 16504 76 P
GOLLERKERI, MDHAN P, 7301 MISSIDN RD STE 339,66208
236-8866
30 M 49516 52 HEM
GDMEZ, FRANCISCD, 4200 SDMERSET #160,66208
649-7300
15 M 26401 43 P
GODD, WENDELL LISLE, 4601 W 109TH,66211
491-9183
24 M 1902 48 FP
GDSALIA, ANIL V, 11701 MACKEY,66210
334-2500
46 M 49501 64 GP
GRASHDFF, JDYCE A, 11116 W 114TH,66210
596-4180
59 F 3005 80 EM
GREENE, LAWRENCE S, 10550 QUIVIRA RD STE 510,66215
492-6200
33 M 3506 54 GE
GRIESHABER, GDRDDN J, 5206 SYCAMDRE,66205
-
54 M 1902 86
GRDSSMAN, HARVEY M, 4601 W 109TH SUITE 122,66211
642-4040
49 M 1902 74 PD
GRUNDMEIER, ANNETTE M, 10550 QUIVIRA SUITE 250,66215
492-2013
46 F 1611 77 PD
HACKER, DAVID CHARLES, 6900 W 67TH,66202
588-6670
50 M 1902 75 ANES
HALL, GARY D, 4902 BRDADMDDR APT 157,66202
-
60 M 1902 88
HAMTIL, LAWRENCE W, 10550 QUIVIRA RD,66215
341-3937
36 M 2803 61 PD
HANDLEY, DENNIS MICHAEL, 8650 W CDLLEGE BLVD,66210
451-1311
50 M 2803 76 FP
HARMDN, GARY S, 6830 W 52ND,66202
-
55 M 1902 81 PM
HARMS, ALBERT C, 4200 W 91ST,66207
381-5550
13 M 1902 38 FP
HARPSTER, GENE D, 4121 W 83RD SUITE 216,66208
648-1400
31 M 1902 57 GS
HARTDNG, TDBY JDSEPH, 8901 W 74TH SUITE 25,66204
362-3210
53 M 1902 78 PD
HARTONG, WILLIAM A, 8901 W 74TH STE 372,66204
831-9300
44 M 1902 71 IM
HARTY, JEAN R, 14604 W 91ST PLACE,66215
492-5260
44 F 1902 85
HATHAWAY, PETER, 11055 CEDAR STE 216,66211
383-2270
31 M 3503 60 IM
HAY, JAMES R, 7720 W 85TH #101,66212
-
58 M 1902
HEDDEN, RICHARD J, 8912 WENDNGA,66206
383-9124
46 M 1902 88
HENDRICKS, WILLIAM J, 9708 W 86TH, 66212
--
60 M 1902 86
HENRY, JDSEPH E, 8901 W 74TH #348,66204
432-8000
42 M 1902 68 PUD
HERRDN, KRISTINE G, 8549 WEDD,66212
-
57 F 1902 84

HESSER, HERBERT H, 7207 EDGEWOOD BLVD,66203
-
06 M 1902 34 OD
HETTINGER, MICHAEL E, 8800 W 75TH SUITE 310,66204
588-6600
46 M 4706 75 OPH
HILL, ROONEY W, 8901 W 74TH SUITE 208,66204
362-6161
47 M 1902 74 IM
HINMAN, MARK W, 9615 MELROSE #1, 66214
--
59 M 1902 86
HITCHCOCK, C THOMAS, 8901 W 74TH SUITE 356,66204
677-2508
47 M GS
HOBSON, MILBURN W, 9119 W 74TH ST,66204
831-2334
30 M 1902 55 OBG
HODES, HERBERT C, 4601 W 109TH #330,66211
381-6868
43 M 1902 69 OBG
HODGES, BRUCE E, 10550 QUIVIRA SUITE 430,55215
888-0777
32 M 1902 63 FP
HOLDEN, JILL K, 11188 BENSON,66210
-
62 F 1902 88
HOOD, ROGER W, 8300 COLLEGE BLVD STE 105,66210
451-9310
48 M 1643 74 ORS
HOPKINS, LENLEY, 8901 W 74TH SUITE 24,66204
722-6121
30 M 3841 56 GS
HOPKINS, WILLIAM O, 8800 W 75TH SUITE 350,66204
831-3500
33 M 2803 61 ORS
HORSEMAN, ROBERT F, 9119 W 74TH ST,66204
432-7419
19 M 1902 44 OBG
HOUSTON II, LAWRENCE MORLEY, 8650 W COLLEGE BLVD,66210
451-1311
50 M 2803 76 FP
HRABIK, BRENT A, 6206 CRAIG,66202
-
61 M 1902 88
HSU, CECILIA, 10550 QUIVIRA SUITE 430,66215
888-0777
43 F 38502 73 PD
HUANG, GEORGIANA L W, 6300 GLENWOOD #3,66202
384-4998
41 F 4107 75 GP
HUMPHREY, LOREN JENKINS, HUMPHREY MED CL & TUM INS,66204
384-2850
31 M 1611 56 SON
HUNKELER, JOHN O, 4601 W 109TH,66211
356-8909
41 M 1902 67 OPH
INNES, ROBERT C, 10226 BRIAR,66207
-
25 M 2802 49 OD
ITURRALDE, GEORGE, 7501 MISSION RD,66208
648-4949
21 M 13201 49 P
JACKSON, ROBERT V, 8901 W 74TH,66204
362-1660
49 M 2803 77 PD
JACOBS, DANIEL H, 6621 OVERHILL,66208
-
61 M 1902 86
JANES, DONALD R, 10550 QUIVIRA #360,66215
492-1955
34 M 1902 60 OBG
JENAB, JOHN, 1903 W 70TH TERR,66208
-
63 M 1902 88
JOHNSON, GARY A, 5106 OUTLOOK,66202
-
55 M 1902 86
JOHNSON, KEITH A, 7630 WINDSOR DR,66208
-
59 M 1902 87
JONES, CHARLES E, SHAWNEE MISSION MED CNTR,66201
676-2214
31 M 1902 60 FP
JONES, DAVID B, 9808 GLENWOOD,66212
-
58 M 1902 84
JONES, H IVOR, 8901 W 74TH SUITE 269,66204
362-4040
24 M 80303 51 P
JOUVENAT, NEIL C, 10550 QUIVIRA SUITE 120,66215
492-1844
43 M 3005 71 OBG
KADIAN, RAJESH S, 10550 QUIVIRA SUITE 260,66215
541-0577
50 M 71 IM

KAGAN, STUART M, 10550 QUIVIRA - SUITE 340,66215
492-1111
44 M 4901 69 PD
KALIVAS, LINDA L, 12300 PAWNEE LN,66209
-
53 F 1902 88
KARLIN, CHARLES A, 7312 ANTIOCH PO BOX 4250,66204
677-0883
49 M 1902 75 DR
KASHYAP, BANSHI PRASAD, 8901 W 74TH SUITE 257,66204
236-4500
47 M 49554 69 IM
KASSER, CHRIS L, 17531 W 70TH,66217
-
53 1902 81 IM
KATZ, FRED S, 8901 W 74TH SUITE 145,66204
722-0020
50 M 1902 79 PS
KEITH, REX B, 9420 MEADOW LANE,66206
-
59 M 1902 85
KELLEY, GORDON R, 4601 W 109TH SUITE 210,66211
341-3040
52 M 6002 77 N
KELLEY, MARSHALL O, 7232 GRANDVIEW DR,66204
-
59 M 1902
KELLY, JIM, 8619 OVERHILL,66206
-
62 M 1902 88
KELLY, MICHELE, 6427 W 51ST TERRACE,66202
362-5141
60 F 1902 87
KENNEDY, KENNETH R, 6100 MARTWAY STE 11,66202
432-0126
24 M 1902 53 FP
KETCHUM, LYNN O, 12301 W 106TH ST,66213
492-3737
36 M 2101 60 PS
KHURANA, SATISH K, 9119 W 74TH SUITE G-2,66204
432-3334
41 M 49536 65 PD
KIMURA, CHARLES C, 8901 W 74TH SUITE 125,66204
262-4220
25 M 2101 56 A
KIMURA, LYLA S, 3504 W 85TH,66206
-
52 F 1902 88
KIMURA, STEPHEN H, 3504 W 85TH,66206
-
59 M 1902 86
KODANAZ, A AYTEKIN, 5710 REINHARDT DR,66205
334-2500
28 M 90201 55 ANES
KOZIKOWSKI, BEN M, 7301 MISSION RD,66208
362-8317
30 M 2834 55 ORS
KRISHNAN, LEELA, 8800 NALL AVE,66207
588-3600
43 F 4802 79 RD
KRUEGER, KURT ALLEN, 10002 HOWE DR,66206
648-0323
48 M 3006 74 ANES
KUBIN, DORIS A, 2504 W 71ST,66208
-
15 F 1902 43 OD
KURTH, PAUL H, 5555 W 58TH,66202
432-2080
53 M 2507 77 IM
KURTH, ROBERT H, 5555 W 58TH,66202
432-2080
28 M 3005 53 IM
LAPI, RUTH M, 2012 STRATFORD RD,66208
-
14 F 4107 37 OD
LARSON, DANUTA DKTAWIEC, 5848 FONTANA DR,66205
-
22 F 80303 50 OD
LASH, RAY E, 8901 W 74TH SUITE 21,66204
722-0080
50 M 1902 75 CD
LAWTON, STEVEN K, 6140 W 51ST APT 1,66202
-
61 M 1902 87
LEAHY, JAMES D, 8220 TRAVIS #115,66204
342-7184
48 M 3005 79 PS
LEATHERS, HOLLIS K PAT, SHAWNEE MISSION MED CNTR,66201
676-2340
38 M 3901 64 PATH
LEE JR, JAMES G, 5739 METCALF CT,66202
371-2330
18 M 1902 44 OBG

LEGASPI JR, PEDRO L, SHAWNEE MISSION MED CNTR,66201
676-2479
36 M 74801 60 ANES
LESTER, JOHN BUCKLES, 4140 W 71ST SUITE 108,66208
432-7276
45 M 1902 70 P
LEWIN, WALTER, 8901 W 74TH ST,66204
362-4040
39 M 1902 56 P
LEWIS, JAMES E, 3700 W 83RD SUITE 203,66208
649-0923
37 M 2101 63 ?
LIPSEY, JAMES H, 8800 W 75TH SUITE 350,66204
831-3500
31 M 1606 56 ORS
LOKER, JAMES L, 9008 W 82ND TERR,66103
-
56 M 1902 86
LUALLIN, SCOTT R, 10812 HAUSER,66210
-
62 M 1902 88
LULO, ANTONIO R, 7600 STATE LN,66208
649-3900
35 M 30801 60 IM
MACDOUGALL, MARGARET L, 6251 ASH,66202
588-6074
48 F 1901 77 NEP
MADISON, RANDALL W, 7711 GARNETT,66215
-
52 M 1902 87
MAGEE, SHAWN M, 6105 W 54TH TERR,66202
-
61 M 1902 87
MALLORY, JOHN A, 10550 QUIVIRA SUITE 510,66215
492-6200
43 M 2803 71 IM
MANLEY, JOSEPH W, PO BOX 7321,66207
381-8838
42 M 1902 69 OBG
MANTZ, FRANK A, 9309 W 103RD,66212
-
12 M 4101 38 OO
MARVIN, NORMAN G, WYCLIFF SHOPPING CENTER,66212
541-8282
29 M 1902 56 FP
MASER, GEORGE R, 5808 NALL,66202
-
12 M 1902 36 OO
MATHEWS, DAVID R, 4601 W 109 SUITE 212,66211
491-4193
53 M 1902 78 FP
MATHEWS, ROBERT MAJOR, 7301 MISSION RD,66208
362-6888
25 M 1902 54 GS
MATZEN, TED A, 7143 CHEROKEE DR,66208
-
52 M 1902 85
MAXWELL, ROBERT A, 8901 W 74TH,66204
362-1660
46 M 1902 73 PD
MC CROSKEY, BRIAN L, 4310 WEST 70TH,66208
-
54 M 1902 79
MCCAUGHEY, HUGH W, 11055 CEDAR SUITE 217,66211
491-3724
28 M 1902 53 IM
MCCOWEN, HERBERT M, 4835 W 62ND TERR,66202
-
58 M 1902
MCDONALD, THOMAS L, 3712 W 48TH,66205
-
53 M 1902 84
MCEACHEN, WILLIAM H, 3700 WEST 83RD SUITE 102,66208
649-3335
32 M 1902 59 ?D
MCWHERTER, LOTTIE B, 5920 NALL SUITE 308,66202
362-1464
30 F 1902 57 IE
MENEZ, CESAR V, 4121 W 83RD SUITE 120,66208
381-4484
35 M 74810 56 P
MERIFIELD, CHRISTOPHER D, 5441 FOXRIDGE #203,66202
-
60 M 1902 87
MILLER, FREEMAN LANCE, 10550 QUIVIRA SUITE 340,66215
492-1111
48 M 1902 74 PD
MISKEW, DON B W, 7301 MISSION RD SUITE 348,66208
362-8317
42 M 6506 69 ORS
MOFFAT, ROBERT E, PO BOX 4250,66204
677-0883
42 M 1902 68 DR
MORITZ, RICK S, 12316 NIEMAN RD,66213
371-4343
54 M 1902 78 DR
MORONEY, JEAN M, 10550 QUIVIRA SUITE 510,66215
492-6200
25 F 4107 65 N
MUEHLBERGER, JAMES J, 4601 W 109TH SUITE 314,66211
491-3242
34 M 3006 60 PD
MUELLER, J KENT, 3700 WEST 83RD SUITE 203,66208
649-0923
35 M 1902 62 P
MUNDEN, FRANK A, 5300 W 94TH TERR,66207
381-4674
38 M 1902 64 A
MURPHY, JAY W, 8901 W 74TH STE 21,66204
362-6161
49 M 3840 73 CD
MURPHY, TIMOTHY P, 5519 STATE PARK RD,66205
-
53 M 1904 87
MURRAY, W LEE, 4601 W 109TH SUITE 225,66211
491-6831
35 M 1902 61 OPH
NASH, ROBERT A, 11111 NALL STE 200,66211
491-6686
31 M 1902 55 P
NAUER, PAULA LOU, 7301 MISSION RD STE 342,66208
384-0745
49 F 1902 74 FP
NAVICKAS, LEONARD A, 8901 W 74TH SUITE 225,66204
362-5510
53 M 1902 77 FP
NAZARIO, LILIANA E, 8170 HALSEY,66215
-
57 F 1902 85
NEIBURGER, JAMES B, 11111 NALL AVE STE 114,66211
491-3300
46 M 1642 72 A
NELSON, BRYAN C, 9119 W 74TH SUITE 107,66204
384-5500
50 M 1902 75 PD
NELSON, CHARLES G, 7217 BEVERLY,66204
-
56 M 1902 86
NELSON, JOHN B, 10550 QUIVIRA SUITE 510,66215
492-6200
48 M 2846 75 ?M
NIEMAN, JOHN L, PO BOX 7426,66207
381-8282
28 M 3806 58 PD
NOSTI, JUAN C, 8901 W 74TH SUITE 345,66204
262-5014
38 M 13204 63 PS
NUNEZ, JULIAN, 10021 MASTIN,66212
-
30 M 27501 60 FP
NYE, C ERIK, 7301 MISSION RD SUITE 348,66208
362-8317
39 M 3520 65 DRS
O'BRYAN, JAMES J, 10550 QUIVIRA,66215
492-2525
47 M 1902 73 PD
OLSON, THOMAS H, 8901 W 74TH SUITE 10,66204
362-1660
54 M 3005 79 PD
ONG, CATHERINE M, 6001 W 90TH TERR,66207
-
60 F 1902 86
OSGOOD, GEORGE M, 3700 W 83RD,66208
381-5200
14 M 1902 44 GP
PATTERSON, JOHN R, 5317 CHADWICK RD,66205
-
20 M 1902 48 OO
PAVELONIS, JOEL D, 5011 LAMAR AVE SUITE 3,66202
-
57 M 1902 87
PEARCE, EUGENE W J, 9119 W 74TH SUITE 104,66204
722-3102
24 M 2802 49 OBG
PEARCE, LUNETTA M, 9119 W 74TH SUITE 104,66204
362-1525
26 F 3005 49 FP
PEARSON, MARK A, 5606 FLOYD APT D,66202
-
55 M 1902 87
PENTECOST, RICHARD L, 6620 RIGGS,66206
-
32 M 1001 56 ?
PERICO, CARLOS J, 9209 ROE AVE,66207
-
32 M 26404 60 FP

PETELIN, JOSEPH B, 8901 W 74TH SUITE 356,66204
677-2508
49 M 1902 76 GPVS
PETERSEN, A GENE, 3700 W 83RD SUITE 104,66208
648-3911
27 M 1902 54 IM
PETERSEN, GERALD O, 3700 WEST 83RD,66208
648-3911
30 M 1902 60 IM
PETERSEN, MARK I, 4956 ADAMS,6620S
722-4185
58 M 1902 84
PETIT, CARL, 10550 QUIVIRA SUITE 240,6621S
888-1114
33 M 60 GS
PETRIE, SAMUEL C, GEORGETOWN MED BLDG,66202
722-1166
27 M 1902 58 IM
PFUETZE, BRUCE L, 4601 W 109TH,66211
383-3630
42 M 1902 68 A
PFUETZE, KARL O, 10550 QUIVIRA SUITE 510,6621S
492-6200
40 M 1902 67 CO
PHILLIPS, WARREN G, 3700 W 83RD,66208
649-0923
26 M 1902 60 D
PILCHARD, WILLIAM A, GEORGETOWN MED BLDG,66204
362-3210
39 M 1602 65 OPH
PINGLETON, WILLIAM WARREN, 8901 W 74TH #348,66204
432-8000
42 M 3901 67 PUD
PITTS, RONALD L, 8901 W 74TH - SUITE 330,66204
362-2524
35 M 2002 62 D
POSS, WILLIAM B, 5808 W 78TH,66208
381-9519
61 M 1902 87
POWELL, CAROL W, 8216 CHEROKEE CIRCLE,66206
381-3785
25 F 1902 51 D
POWELL, KENNETH A, 8216 CHEROKEE CIRCLE,66206
753-7000
25 M 1902 53 IM

PRENDES, CARLOS A, 5750 W 95TH #225, 66207
381-5550
50 M 3005 79 GP

PRONKO, MICHAEL J, 4121 W 83RD SUITE 223,66208
648-7878
34 M 1902 60 P
QUIGLEY, JAMES, SHAWNEE MISSION MED CTR,66201
676-2340
50 M 2803 77 PATH
RALSTIN, JAMES H, 14708 W 71ST TERR,66215
299-2069
49 M 1902 74 IM
RANDOLPH III, RICHARD J, 3901 ELLEDGE RD,6620S
-
54 M 1902 87
RAY, LARRY D, 2600 N 10STH,66206
-
55 M 1902 87
REINTJES, STEPHEN L, 2901 W 73RD,66208
-
57 M 1901 83 NS
REISZ, COLLEEN C, 2220 W 71ST,66208
-
55 F 1902 88
REIVICH, RONALD S, 8900 STATE LN #331,66206
383-3050
34 M 3806 60 P
RICE, BERNARD F, 8901 W 74TH SUITE 125,66204
262-9222
31 M 4113 56 END
RICHTER, DON G, SHAWNEE MISSION MED CTR,66201
676-2464
50 M 1902 79 ANES
RICK JR, GREGORY G, THE GEORGETOWN MED BLDG,66204
831-9300
40 M 1902 66 GE
RIESENMY, BRANDON D, 5538 REEDS,66202
-
60 M 1902 87
RIFFEL, LAWRENCE D, 10550 QUIVIRA SUITE 270,6621S
492-5456
53 M 1902 78 IM
ROBERTSON, EDWARD J, SHAWNEE MISSION MED CTR,66201
676-2479
46 M 1902 78 ANES
ROBINSON, JOHN D, 74TH & GRANDVIEW,66201
576-2479
48 M 1902 74 ANES
RODRIGUEZ, BEATRIZ M, 5012 REINHARDT,66205
-
58 F 1902 88
ROSENBERG, STANTON L, 1900 W 75TH SUITE 200,66208
362-8080
30 M 1902 55 D
ROWDON, GREGORY A, 8830 PFLUMM RD APT 203,66215
-
57 M 1902 88
RUBIN, HERBERT M, 10550 QUIVIRA - SUITE 340,66215
792-4220
37 M 2803 63 PD
RUMOLD, MERVIN J, 6340 INDIAN LANE,66208
-
03 M 1902 30 GS
RUSSELL, BRIAN K, 2200 W 48TH TERRACE, 66205
--
57 M 1645 83 NS
RYAN, MICHAEL E, 4601 W 109TH SUITE 210,66211
491-4330
46 M 1902 72 N
RYMER, ROBERT A, 8901 W 74TH SUITE 373,66208
722-0170
41 M 0702 68 OPH
SACHEN, FREDERICK L, 9620 ROE,66207
-
45 M 4813 79 N
SAFFO, KARL S, 8901 W 74TH,66204
362-9585
39 M 52801 62 DS
SANDENO, CRAIG A, 10046 ROSEHILL,66215
-
62 M 1902 88
SATHYANARAYANA, SARASWATHI, 8901 W 74TH SUITE 20,66204
677-2281
45 F 49509 67 OBG
SAWKAR, LAXMIDAS A, 8901 W 74TH SUITE 312,66204
384-4844
36 M 49523 63 ON
SCHAEFER, JOSEPH PETER, 10550 QUIVIRA - SUITE 230,6621S
492-7440
34 M 1902 60 IM
SCHREPFER, ROSEMARY, 9119 W 74TH #104, 66204
722-3102
22 F 1902 47 OBG
SCHROLL, JOHN T, 7406 FLINT APT 102, 66203
384-4990
51 M 1902 76 OBG
SCHUPP, ELIZABETH A, 8705 W 65TH APT 103,66202
-
57 F 1902 87
SCHUSTER, MICHAEL R, 6427 HALLET,66216
-
56 M 1902 87
SCLAR, WILLIAM C, DOCTORS BLDG SUITE 450,66215
492-7730
46 M 2501 72 GS
SCOTT, JUDITH C, 2041 W 84TH TERR,66206
-
F 1902 86
SEGRAVES, STEVEN D, 7800 GLENWOOD,66204
-
59 M 1902 86
SELLERS, JEFF D, 9158 SOMERSET,66207
-
55 M 1902 86
SHAAD, DOROTHY J, 2322 W 51ST,66205
-
09 F 1902 44 DO
SHAFFER, KATHLEEN BRAY, 9119 W 74TH SUITE 107,66204
384-5500
54 F 2846 79 PD
SHAFFER, STANLEY G, 9119 W 74TH SUITE 107,66204
384-5500
55 M 2846 79 PD
SHEEHAN, MAUREEN H, 5926 WOODSON #203,66202
-
60 F 1902 86
SHERIDAN, RANDY M, 8901 W 74TH SUITE 36,66204
236-6455
53 M 1902 78 OBG
SHOFSTALL, WILLIAM H, 6701 WEST 56TH,66202
-
11 M 3901 41 DO
SHORT, BRUCE H, 10550 QUIVIRA SUITE 270,66215
492-5456
51 M 1902 77 IM
SHULTZ, WILLIAM H, 9400 ENSLEY LN,66206
-
60 M 1902 87
SILLS, THOMAS D, 8309 MULLEN RD,6621S
281-8883
49 M 5606 77 EM

SILVER, BRADO J, 8901 W 74TH SUITE 30,66204
432-2280
50 M 1205 76 IM
SIMONY, M ANN, 5020 SOUTHRIDGE,66205
-
58 F 1902 87
SMITH, DALE C, 4601 W 109TH ST SUITE 224,66211
381-0353
20 M 1902 45 OPH
SMITH, DONALD J, 8600 W 95TH ST,66212
642-4515
18 M 1902 49 FP
SMITH, WILLIAM P, PO BOX 4250,66204
677-0883
51 M 1902 77 R
SNODELL, FIRMIN E, 5555 W 58TH,66202
432-2080
31 M 1902 61 IM
SNOW JR, ARTHUR O, 8901 W 74TH - SUITE 225,66204
362-5510
45 M 1902 75 FP
SOELONER, JAMES O, 8901 W 74TH SUITE 24,66204
722-6214
44 M 1902 70 FP
SPERRY, ROBERT E, 6701 W 87TH APT 101,66212
-
59 M 1902 86
STAMOS, GEORGE E, 10550 QUIVIRA,66215
492-5456
46 M 1803 72 IM
STEINBERGER, CRISTINE C, 7603 MONROVIA, 66216
--
61 F 1902 88
STEVENSON, E KENT, 4121 W 83RD SUITE 150,66208
649-5566
45 M 2802 67 CHP
STRIEBINGER, CHARLES M, 4601 W 109TH SUITE 307,66211
341-7299
45 M 1606 67 NS
STUBER, JACK LAWRENCE, PO BOX 4250,66204
677-0883
40 M 1902 66 DR
STUCKEY, CHARLES E, 10550 QUIVIRA SUITE 240,66215
492-7737
41 M 3005 68 GS
SUGAR, ROBERT L, 8901 W 74TH SUITE 248,66204
384-4990
40 M 3508 66 OBG
SULLIVAN, TOM G, 10550 QUIVIRA SUITE 320,66215
492-3600
44 M 1902 71 OBG
SULLIVAN JR, HENRY B, 5817 NIEMAN RD,66203
631-6160
24 M 1902 52 FP
SUTTON JR, RICHARD L, 3203 W 83RD TERR,66206
-
08 M 2501 29 OO
TAIT, AMY S, 5959 DEARBORN #304,66202
-
58 F 1902 86
TAIT, LAYNE S, 5959 DEARBORN #304,66202
-
59 M 1902 86
TALLEY, ROBERT L, 6501 W 101 ST PLACE,66212
588-3000
48 M 4802 74 IM
TARVIN, RANDY J, 4782 SKYLINE,66205
-
59 M 1902 86
TAYLOR, THOMAS L, 8901 W 74TH SUITE 34,66204
362-9444
40 M 1902 66 GS
TENNY, ROBERT T, 4601 W 109TH SUITE 307,66211
341-7299
51 M 1902 76 NS
TETZLAFF, ARCH O A, 4520 W 65TH,66208
334-2500
26 M 40721 52 ANES
THOMSEN, GARY, 8901 W 74TH SUITE 225,66204
362-5510
51 M 3005 76 FP
THORNTON, CAROLYN SUE, 8532 BENSON,66212
-
59 F 1902 86
THORNTON, REBECCA R, 5708 OUTLOOK APT 301,66202
-
61 F 1902 88
TOALSON, WILLIAM B, 8901 W 74TH SUITE 21,66204
722-0080
37 M 1902 63 CO
TRETBAR, LAWRENCE L, 8901 W 74TH,66204
677-1776
33 M 1902 60 GS
TROWBRIDGE, DENISE R, 12606 W 110 TER,66210
-
61 F 1902 87
TUCKER, SHERIDAN G, 4121 W 83RD SUITE 150,66208
649-5566
50 M 1902 75 CHP
VALK, WILLIAM L, 5401 W 81ST,66208
588-6146
09 M 2501 37 U
VANNAMAN, DONALD D, P O BOX 7426,66207
381-8282
43 M 1902 71 PD
VENNEMAN II, CHARLES R, 10505 W 89TH,66214
-
53 M 1902
VILE, SHELDON B, 8341 BRIAR,66207
-
61 M 1902 87
VILLANUEVA, CESAR L, 6332 ASH,66208
-
39 M 74802 65 OBG
VORAN, DAVID A, 8629 RILEY,66212
-
50 M 1902 88
WANG, SIDNEY W, 10550 QUIVIRA SUITE 130,66215
492-1500
32 M 38503 58 FP
WARD, WENDY L, 14050 SWITZER, 66221
--
62 F 1902 88
WATANABE, MASAYO, 5801 W 92ND TERR,66207
-
60 M 1902 86
WAXMAN, DAVID, 12516 W 85TH TERR,66215
888-7889
18 M 3515 50 IM
WAXMAN, STEVE W, 12516 W 85TH TERRACE, 66215
--
60 M 1902 86
WEBB, JAMES R, 5949 NIEMAN ROAD,66203
631-0900
34 M 1902 61 FP
WEINGART, JAMES H, 4717 W 70TH,66208
-
58 M 1902 84
WELLING, PAUL A, 6105 W 54 TERR,66202
-
61 M 1902 87
WELTON, THOMAS C, PO BOX 6811,66206
-
61 M 1902 88
WHITE, JOHN P, 8347 VALLEY VIEW,66212
-
17 M 1902 42 OO
WHITEHEAD, RICHARD E, 7301 MISSION RD,66208
362-8317
31 M 2501 58 ORS
WHITLEY, DOUGLAS M, 4601 W 109TH SUITE 202,66211
341-4770
34 M 1902 60 D
WIEN, STEVEN M, 12456 W 62ND TERR,66203
268-4454
50 M 1902 79 FP
WIGGINTON, GERALD O, O.O., 9119 W 74TH SUITE 107,66204
384-5500
44 M 2878 70 PD
WILEY, JOHN H, 9119 W 74TH SUITE 201,66204
831-2334
37 M 4113 63 OBG
WILEY, THOMAS M, 11817 MACKEY,66210
-
59 M 1902
WILLIAMS, CARL M, 4902 BROADMOOR APT 157,66202
-
55 M 1902 88
WILLIAMS, THOMAS A, 10550 QUIVIRA #310,66215
894-6317
36 M 1902 62 FP
WILSON, ROBERT B, 10925 W 98TH,66214
-
10 M 1902 40 OO
WILSON, SLOAN J, 5618 W 62ND,66202
-
10 M 1902 36 HEM
WOOD, FRED M, 8901 W 74TH SUITE 124,66204
831-2604
38 M 4706 62 ORS
WOODS, DENNIS O, 5435 BRIAR,66205
-
60 M 1902
WOODS, GREGORY A, 5300 W 49TH,66205
-
56 M 1902 83 ORS

WOODS, MICHAEL S, 6220 W 51ST APT 2,66202
-
61 M 1902 87
WRIGHT III, ROBERT W, 5436 WINDSOR LN, 66205
588-6670
50 M 1902 61 P
WURSTER, GEORGE R, 3700 W 83RD SUITE 203,66208
649-0923
35 M 1902 61 P
YE, RICHARD C, 7301 MISSION RD,66208
362-7505
20 M 24222 46 PS
YOHE, RUTH M, 8600 W 95TH ST,66212
383-3377
26 F 4107 54 PDA
YOUNG, JOHN W, 8220 TRAVIS STE 115,66204
383-1550
37 M 4706 63 PS
ZACK, ASHLEY S, 4601 WEST 109TH SUITE 122,66211
642-4040
46 M 2803 73 PD
ZAMIERDWSKI, DAVID S, 8800 W 75TH SUITE 340,66204
831-4113
42 M 2307 68 PS
ZIMMERMAN, DANIEL D, 4761 RAINBOW,6620S
831-0910
45 M 3005 70 IM

SMITH CENTER—913
(Central Kansas Society)

BARNES, JOE L, 119 E PARLIAMENT,66967
-
54 M 1902 82 FP
SHEPPARD, ROBERT G, 120 E COURT,66967
282-6654
21 M 1902 45 GS
STEINKRUGER, VERLYN WILLIAM, 120 E COURT,66967
282-6654
28 M 3005 53 FP
WOODS, HUGH J, 120 EAST COURT,66967
282-6654
26 M 1902 52 FP

SOUTH HAVEN—316
(Tri-County Society)

UBELAKER, ERNEST J, ,67140
892-2261
11 M 1902 38 FP

ST. FRANCIS—913
(Northwest Kansas Society)

CRAM, ERNEST R, PO BOX 625,67756
332-2126
24 M 1902 52 FP
JEWELL, ROSS L, 203 E SPENCER,67756
332-2832
13 M 1902 56 FP
STEPHENSON, LUCILLE C, BOX 824,67756
-
06 F 1902 32 FP

ST. MARYS—913
(Pottawatomie County Society)

BROWN, FRED E, 602 W PALMER,66536
437-2256
26 M 1902 55 FP

STAFFORD — 316
(Ninnescah Society)

BROWN, C EVERETT, PO BOX E,67578
234-5251
10 M 1902 47 A
FARMER III, F J, D.O., PO BOX 309,67578
234-6826
52 M 2878 79 FP
QUIJANO JR, RAMON S, 412 E GRAN,67578
234-5236
45 M 74811 71 GP

STERLING—316
(Rice County Society)

DYSART, JACK C, 224 N FOURTH,67579
278-2181
12 M 3901 39 DO
SIMPSON, TOM C, 239 N BROADWAY,67579
278-2123
47 M 1902 73 FP

STILLWELL—913

STINGO, ANDREW J, 5708 W 164TH,6608S
-
61 M 1902 87

STOCKTON—913
(Central Kansas Society)

MAUCK, HAROLD C, 623 SOUTH 2ND,67669
425-6280
20 M 1902 54 FP
VOTAPKA, WILLIAM L, 623 S SECOND,67669
425-6280
24 M 1902 53 FP

SUBLETTE—316
(Southwest Kansas Society)

THIEMANN, A H, O.D., 301 DERBY,67877
675-2241
12 M 1805 42 FP

SYRACUSE—316
(Southwest Kansas Society)

PETTERSON, CECIL E, PROFESSIONAL ASSOCIATION,67878
384-5731
14 M 1902 39 FP
SHARMA, S A, PO BOX 1087,67878
384-7735
44 F 49530 68 PD

TONGANOXIE—913
(Leavenworth County Society)

STEVENS, PHILIP L, BOX 319,66086
845-2090
27 M 1902 54 FP

TOPEKA—913
(Shawnee County Society)

AGAN, LAWRENCE M, 1314 PEMBROKE LN,66604
357-4306
20 M 5002 44 R
ARJUNAN, K N, 901 GARFIELD,66606
357-6171
44 M 49568 73 MS
ARREDONDO, MARIO, 5814 SW 26TH, 66614
296-7216
25 M 26401 54 P
ARUNAKUL, PUNYA, 1710 W TENTH,66604
234-2624
44 M 89104 69 OTD
ASHLEY, BYRON J, 3222 PLASS,66611
233-2280
98 M 1902 24 DPH
ASHLEY JR, B JOHN, 1616 WEST 8TH ST,66606
233-2280
31 M 1902 56 OPH
ATLURU, NARAYANA RAO, 5207 W 11TH TERR,66604
232-8761
47 M 49550 69 CO
AVERILL, STUART C, MENNINGER FO,66601
273-7500
24 M 502 52 P
BAEHR, RALPH H, S-F CAP REG RADIOTHER CTR,66606
295-8008
35 M 1606 59 R

BAIR, GLENN O, 634 MULVANE SUITE 400,66606
233-5153
31 M 2401 57 IM

BAKER, FREDERICK C, 2101 WEST 10TH,66604
232-0909
35 M 4113 62 FP

BAKER, PHILLIP L, 909 MULVANE,66606
357-0301
37 M 3005 63 ORS

BAKER, RAY O, 1615 W EIGHTH,66601
233-8961
30 M 4812 55 GPM

BARABAN, MARC R, 1319 HUNTOON,66604
357-5325
50 M 2846 75 PS

BAUCOM-COPELAND, SHARON LAVARNE, 634 MULVANE STE 402,6660
235-9544
50 F 2846 75 FP

BEACH, RICHARD R, 3023 SW CLARK CT,66604
-
23 M 2802 48 OO

BEALE, DAVID A, PO BOX 829, 66601
273-7500
31 M 5404 56 P

BECK, JOSEPH O, 2760 SW BURLINGAME,6661I
-
18 M 3005 43 OO

BEDFORD, O R, PO BOX 1772,66615
-
09 M 4802 40 IM

BEELMAN, FLOYD C, 1286 LAKESIDE DR,66604
-
02 M 3840 35 FP

BELLER, WILLIS L, 31 PEPPERTREE LANE,66611
-
14 M 1902 41 OO

BLAKE, HENRY S, 1933 WESTWOOD DR,66604
-
11 M 3520 37 OO

BONEBRAKE, C RICHARD, 634 MULVANE STE 104,66606
233-1979
48 M 1606 75 OBG

BOREL, DAVID, ST FRANCIS HOSP & MED CTR,66606
295-8473
45 M 1902 71 PATH

BOWEN, CLOVIS W, 2200 WEST 10TH,66604
234-8601
12 M 1902 37 FP

BOWEN JR, HARRY J, 2200 WEST 10TH,66604
234-8601
1I M 1902 37 FP

BOYD, SPENCER H, 1815 WEST 2ND,66606
-
11 M 1902 35 OBG

BRAHMAN, HERBERT D, 1700 SEVENTH,66606
295-8471
43 M 512 70 PATH

BRAUN, ROBERT W, 901 GARFIELD,66606
354-9591
44 M 2803 70 IM

BRIDWELL, RUSSELL E, 1710 W TENTH,66604
234-2624
26 M 1902 51 ENT

BUSKIRK, STEVEN J, 310 MED ARTS BLDG,66604
295-8008
54 M 3005 79 TR

CACHIA, RICHARD M, DEPT OF PATHOLOGY,66606
295-8472
51 M 62701 73 PATH

CASHMAN JR, MAURICE R, 901 GARFIELD,66606
354-9591
35 M 1902 6I HEM

CHAMBERLIN JR, CECIL R, BOX 829,66601
273-7500
30 M 3901 55 CHP

CHEN, CHU-CHI, 918 W TENTH,66604
354-4465
47 M 24405 73 U

CHEN, TAK-MING, 308 MED ARTS BLDG,66604
234-3451
4I M 24402 68 ANES

CHERRY JR, ARTHUR C, 918 WEST 10TH,66604
233-3362
27 M 3806 53 PD

CLARK, CRAIG N, 300 SE NORWOOD,66607
354-7683
29 M 1902 58 FP

COCHRAN, PAUL W, MENNINGER FD,66601
273-7500
33 M 4802 58 IM

COHEN, LOUIS, 918 W 10TH,66604
233-7175
I4 M 1902 41 IM

COKELEY, JOHN M, 2200 GAGE BOULEVARD,66622
272-3111
30 M 5104 55 P

COKER, W LAURENCE, 631 HORNE #340,66606
232-9394
53 M 1902 78 FP

COLLINS, DEAN T, MENNINGER FD,66601
273-7500
28 M 1902 55 P

COLLINS, EDWARD JOSEPH, 900 WASHBURN,66606
233-3242
45 M 1611 71 OPH

COLLINS, ELISABETH B, 634 MULVANE #402,66606
233-6399
21 F 40905 46 P

COLLINS, FRANCIS T, 206 MED ARTS BLDG EAST,66604
233-6470
I4 M 1902 43 IM

CONROY, ROBERT W, MENNINGER FD,66601
273-7500
38 M 2604 64 P

COOLEY, DENNIS M, TOPEKA MEDICAL CENTER,66604
233-3362
51 M 1902 77 PD

COPPLE JR, HAL E, 904 SW MULVANE,66606
232-8224
46 M 3002 78 PDNE

COTTON, ROBERT T, 901 GARFIELD,66606
354-9591
19 M 1902 45 IM

CRARY, JOHN E, 201 MED PLAZA BLDG,66604
233-4202
I8 M 1902 43 IM

CRIDER, KAY L, 634 MULVANE SUITE 402,66606
235-9544
49 F 1902 77 FP

CROUCH, STEVEN W, 904 MULVANE,66606
232-8224
51 M 1902 76 PD

CRDUCH, WILLIAM H, 904 MULVANE,66606
232-8224
20 M 2802 45 PD

DAVIS, CHESTER R, 631 HORNE,66606
232-6020
50 M 1902 75 FP

DELGADO, SERGIO, 634 MULVANE STE 200,66606
357-0352
37 M 2501 62 ORS

DESOIGNIE, RAFAEL R, 2537 BURNETT RD, 66614
--
19 M 27501 00

DUNAGIN, JACK A, 925 WESTERN,66606
233-7138
20 M 1902 44 P

DUNIVEN, PHILIP L, RADIOLOGY & NUCLEAR MED,66604
234-3451
52 M 4812 77 R

DURST JR, ROBERT D, 1706 SW TENTH,66604
357-5166
42 M 2803 69 D

EATON, EDWARD L, 925 WESTERN,66606
233-7138
40 M 0401 73 P

EDMONDS, MARTA J, 1201 WEBSTER,66604
232-4333
52 F 1902 88

ELDER, DOUGLAS M, 310 MED ARTS BLDG,66604
234-3451
4I M 1902 69 OR

FEAGAN, JERRY, 901 GARFIELD,66606
354-9591
39 M 1902 63 GE

FERNANDEZ, LUIS A, 2707 WEST 13TH,66604
233-8961
14 M 27501 41 PD

FERNANDEZ, MIGUEL A, 1029 WESTERN APT B,66604
-
43 M 27502 69 GS

FIELD, RICHARD A, 308 MED ARTS BLDG,66604
235-3451
29 M 1902 55 ANES

FILLMAN, ELDON M, 301 MEDICAL PLAZA BLDG,66604
233-4256
20 M 1611 44 U

FORD, FRED L, 1264 LAKESIDE DR,66604
-
11 M 2501 36 GS

FOSTER, D BERNARD, 3111 JEWELL,66611
272-3111
14 M 2501 38 NP
FRANKLIN JR, BENJAMIN A, 1001 HORNE #310,66604
234-3451
45 M 1902 76 R
GANDHI, SHANTIKUMAR K, 634 SW MULVANE SUITE 203,66606
233-1690
40 M 49501 67 TS
GANZARAIN, RAMON C, MENNINGER FD,66601
273-7500
23 M 23101 47 P
GAY, JOHN D, 310 MED ARTS BLDG,66604
234-3451
42 M 4802 68 DR
GEIS, DICK A, 7046 NW 74TH, 66618
354-5100
47 M 1902 73 IM
GENDEL, JOSEPH E, 918 W 10TH,66604
235-9914
12 M 4804 37 DRS
GIESSEL, MICHAEL D, 901 GARFIELD,66606
354-9591
48 M 1902 74 D
GIMPLE, KENNETH, 631 HORNE #200,66606
233-7491
45 M 1902 71 ORS
GLEASON, JIMMIE A, 800 LINCOLN,66606
233-5101
33 M 1902 58 OBG
GOERING, EMIL L, SECURITY BENEFIT LIFE,66636
295-3175
27 M 1902 57 IM
GRAHAM JR, CHARLES P, 1501 SW 6TH, 66606
354-9504
40 M 3601 65 GS
GRAY, DAVID E, 3633 SW DRURY LN,66604
16 M 1606 42 OO
GRAYIB, ANTOINE S, 1625 OAKLEY,66604
354-5100
18 M 60501 46 IM
GREENBERG, MARK, 310 MED ARTS BLDG,66604
234-3451
46 M 1611 72 R
GREENE, HORACE T, 1710 W 10TH,66604
354-7508
15 M 401 42 FP
GREENE, RUSSELL E, 6800 SW AYLESBURY RD,66610
295-8008
53 M 515 79 RT
GREENWOOD, EDWARD D, 1915 WEBSTER,66604
01 M 702 38 CHP
GREER, RICHARD H, 918 W 10TH,66604
233-5084
09 M 1902 39 DO
GUTOVITZ, ALLEN LOUIS, 634 MULVANE SUITE 100,66606
233-9643
46 M 1611 72 CD
HACKER, ELAINE MARY, 3026 QUAIL CREEK,66614
296-3981
25 F 2604 50 OBG
HALLEY, M MARTIN, 40 MED ARTS BLDG,66604
233-1710
27 M 2401 53 TS
HARRIS, HUBERT L, 210 MED ARTS BLDG,66604
233-3151
12 M 1803 39 D
HARRIS, PATRICIA A, 1617 W 26TH,66611
354-1906
29 F 1902 54 IM
HARRISON, HALL E, 901 GARFIELD,66606
354-9591
39 M 2802 65 IM
HARVEY, R CLAY, 1001 HORNE #310,66604
234-3451
52 M 1902 78 R
HEBBAR, SATYA N, 634 MULVANE SUITE 100,66606
233-9643
39 M 49509 62 CD
HEEB, CAMILE, 918 W TENTH,66604
233-0912
44 1902 79 PD
HERRERA, JORGE J, 2825 CALIFORNIA,66605
267-5370
27 M 64901 55 IM
HICKMAN, JAMES STEPHEN, 634 MULVANE SUITE 103,66606
233-8508
53 M 2803 79 PD
HIEBERT, JOHN B, 901 GARFIELD,66606
354-9591
40 M 1902 68 CD
HILL, ROBERT N, 901 GARFIELD,66606
354-9591
14 M 1902 67 IM
HILST, WILBUR D, 1271 WOODHULL,66604
273-5870
31 M 3005 55 GS

HIRSCHBERG, J COTTER, MENNINGER FD,66601
273-7500
15 M 1602 40 CHP
HISZCZYNSKYJ, ROMAN, 1500 W TENTH,66606
354-6870
35 M 1803 66 PATH
HOBBS, DONALD D, 200 CONTINENTAL MED BLDG,66606
233-7491
28 M 2401 54 ORS
HOHERZ, DAVID G, 631 HORNE SUITE 220,66605
235-1170
45 M 1803 72 TS
HOLMES, ROBERT W, 901 GARFIELD,66606
354-9591
52 M 1902 74 IM
HORNE, JAMES B, 1305 LAKESIDE DR,66604
272-3111
26 M 1606 52 P
HOSTETTER, JAMES P, 1500 W TENTH,66606
354-6100
43 M 1902 69 EM
HOSTETTER, MARCIA MORGAN, 634 MULVANE #104, 66606
233-1979
46 F 1902 69 OBG
HOYT, ARTHUR W, 2521 NW 35TH,66618
234-5663
14 M 2501 40 P
HSU, CHENG H, 1516 W SIXTH,66606
232-1005
41 M 38502 66 U
HSU, SHIN-FU, MEDICAL PLAZA BLDG,66604
232-0362
43 M 24402 68 OTO
HUANG, JONSON, 901 GARFIELD,66606
357-6171
52 M 2701 77 N
HUSTON, JOSEPH W, 634 MULVANE,66606
357-0352
35 M 1902 62 ORS
HUTTON, FREDERICK A, 102 MED PLAZA BLDG,66604
234-0553
29 M 6701 58 PS
HYLAND, JOSEPH M, BOX 829, 66601
273-7500
45 M 53902 68 P
ILIFF, R DOUGLAS, 1500 SW OAKLEY,66604
354-6100
49 M 1902 74 FP
ILORETA, ALFREDO T, 1516 W SIXTH,66606
232-1005
47 M 74801 71 U
ISAACSON, RICHARD N, 1001 GARFIELD STE 301,66604
233-4256
48 M 2501 75 U
JACKSON JR, DONALD H, 634 MULVANE #100,66606
233-9643
40 M 3515 69 CD
JACOBY II, ROBERT E, 340 CONT MED BLDG,66606
232-9394
46 M 2307 72 FP
JANSSEN, ERWIN T, MENNINGER FD,66601
273-7500
36 M 1803 62 P
JOSEPH, BRIAN W, 3600 SW BURLINGAME,66611
267-0150
38 M 35205 61 CHP
JOSS, CHARLES S, 1400 STRATFORD,66604
14 M 1606 40 OO
JOYCE, G BERNARD, 4929 WEST HILLS DR,66606
17 M 1902 44 OO
KATZ, JEROME B, BOX 829,66601
273-7500
22 M 2101 44 P
KAVEL, KARL K, MED PLAZA BLDG,66604
234-2663
36 M 3605 64 PDA
KEARNS, NORBERT W, BOX 829,66601
273-7500
43 M 1002 70 P
KELLY, DAN A, 904 MULVANE,66606
232-8224
39 M 2803 64 PD
KEYS JR, ROBERT C, 308 MED ARTS BLDG,66604
235-3451
36 M 1902 62 ANES
KEYS SR, ROBERT C, 3034 LYDIA,66614
97 M 1902 27 OD
KIM, YONG W, CONT MED BLDG,66606
232-6964
28 M 58302 49 IM
KINDLING, PAUL H, 40 MED ARTS BLDG,66604
233-1710
30 M 3545 61 TS
KIRKEGAARD, RODGER S, 835 WESTERN,66606
233-6493
30 M 1803 56 OPH

KLEINHOLZ JR, EMIL JOHN, 634 MULVANE #201,66606
232-1227
39 M 3503 65 IM
KLEMMER, HERBERT, 904 MULVANE MED PARK CL,66606
233-5033
11 M 4102 37 P
KODNTZ, JUDITH A, 904 MULVANE MED PARK CL,66606
233-5033
49 F 1902 75 CHP
KOVARIK, ERNEST D, 900 WASHBURN,66606
233-1800
36 M 3005 64 DPH
KOWALSKI, PETER C, BOX 829,66601
273-7500
57 M 3901 83 P
KOWALSKI, STEPHEN F, 1417 SW MACVICAR,66604
273-7500
55 M 3901 81 P
KROLL, HARRY G, 200 CONTINENTAL MED BLDG,66606
233-7491
24 M 1602 50 ORS
LACCHED, MICHAEL L, 2115 W 10TH,66604
354-4600
51 M 3840 76 FP
LAI, MAX G, 918 W TENTH,66604
354-4465
45 M 24405 72 U
LAI-CHEN, SHEUE-HUEY, 918 W TENTH,66604
354-4465
48 F 38505 73 GP
LAUNEY, WALTON S, 1001 HORNE #310,66604
234-3451
39 M 4804 75 R
LAWSON, DWIGHT, 1203 SW 29TH,66611
-
06 M 2802 30 IM
LEE, SONG DOW, 308 MED ARTS BLDG,66604
235-3451
43 M 38505 68 ANES
LEE, SONG PING, 918 W 10TH,66604
233-6001
34 M 38502 61 OTO
LEIFER, WILLIAM N, 1500 W TENTH,66606
354-6870
47 M 1902 73 PATH
LENTZ, WILLIAM R, 300 MEDICAL ARTS BLDG,66604
235-3443
24 M 1902 53 FP
LESSENDEN JR, C M, 5635 NW BRICKYARD RD,66618
272-3111
18 M 1902 43 D
LEVY, EDWIN Z, 4125 SW GAGE CTR DR L-#6,66604
273-5610
29 M 1606 54 P
LIESMANN, GEORGE E, 631 HORNE SUITE 220,66606
235-1170
49 M 1902 74 GPVS
LIESMANN, JEAN ELIZABETH, MEMORIAL HOSP,66607
354-5164
49 F 1902 74 IM
LUI, WASON, 1516 W SIXTH,66606
233-1747
48 M 1606 77 GPVS
LUMB, RAYMOND C, 901 GARFIELD,66606
354-9591
42 M 1001 68 RHU
LYNCH, JOHN A, 909 MULVANE,66606
357-0301
30 M 2834 55 ORS
MACARTHUR, RICHARD IAN, 634 SW MULVANE,66606
233-1690
46 M 1902 74 GS
MARSHALL, B M, 1826 SW 34TH,66611
-
08 M 2802 34 U
MARTIN, WILLIAM D, 308 MED ARTS BLDG,66604
235-3451
19 M 1902 44 ANES
MARTINAK, JOSEPH F, 5144 SW VORSE RD,66614
-
39 M 3506 66 EM
MAU, WALTER, 301 MEDICAL PLAZA BLDG,66604
233-4256
16 M 1611 40 U
MCCARTER, DUANE K, 2101 W 10TH,66604
233-8979
26 M 1902 58 IM
MCCLELLAN, JOHN W, 2701 BOSWELL,66611
-
11 M 3006 36 OO
MCCLURE, JAMES A, 1541 WESTOVER RD,66604
-
18 M 1902 44 DD

MCCOMAS JR, MARMADUKE D, 3020 BRUSH CREEK CIRCLE,66614
-
16 M 1902 43 DO
MCCOY, MICHAEL T, 909 MULVANE,66606
357-0301
49 M 1902 75 ORS
MCELROY, ROBERT T, 221 MED ARTS BLDG,66604
232-0444
35 M 1902 61 GS
MCELROY, WILBUR J, 1616 W EIGHTH,66606
233-2280
35 M 1902 61 OPH
MCKINNEY, SHARON L, O.D., 5201 BELLE TERR,66604
272-3111
41 F 2878 83 RM
MECH, ARNOLD W, 3240 TIMBERLAKE LN,66614
273-7500
52 M 1643 77 P
MEGIBOW, ALAN O, 925 WESTERN,66606
233-7138
37 M 3503 64 CHP
MEIDINGER, RICHARD, 310 MED ARTS BLDG,66604
295-8011
39 M 1902 65 OR
MENNINGER, KARL A, BOX 829,66601
273-7500
93 M 2401 17 P
MENNINGER, ROBERT G, 234 KANSAS,66603
232-7214
22 M 3545 52 P
MENNINGER, ROY W, BOX 829,66601
273-7500
26 M 3520 51 P
MENNINGER, W WALTER, THE MENNINGER FD,66601
273-7500
31 M 3520 57 P
MEYER, MARK E, 3309 SW STONE,66614
677-4818
58 M 1902
MEYER, O WARREN, 634 MULVANE #100,66606
233-9643
49 M 1902 74 CD
MHATRE, VIJAY R, 600 SE MADISON,66607
354-5275
49 M 49528 67 IM
MILLS JR, PHILIP E, 901 GARFIELD,66606
357-6171
36 M 1902 64 N
MODLIN, HERBERT C, MENNINGER FD,66601
273-7500
13 M 3005 38 P
MOORE, HUGH C, 1500 W TENTH,66606
354-6870
33 M 4812 59 PATH
MORRIS, MERLE D, 1401 W 10TH,66604
234-2877
21 M 1902 45 OBG
MORRISON, MICHAEL R, 800 LINCOLN,66606
233-5101
50 M 1902 76 OBG
MORROW JR, J TARLTON, 235 WOODLAWN,66606
-
23 M 4804 47 DD
MUELLER, ARNOLD V, 901 GARFIELD,66606
354-9591
31 M 3005 57 IM
MYERS, JO ANN, MENNINGER FD,66601
273-7500
28 F 1902 53 P
NABOURS, RICHARD O, 4228 W 29TH ST TERR,66614
272-7190
27 M 1902 54 FP
NANCE, JOEL, MENNINGER FOUNDATION, 66601
273-7500
42 M 3546 72 P
NATHAN, WILLIAM A, 904 MULVANE,66606
233-5033
48 M 3503 72 CHP
NICE, G WILLIAM, 112 MED ARTS BLDG EAST,66604
235-8090
22 M 1902 46 IM
NOVOTNY, PETER C, MENNINGER FD,66601
273-7500
30 M 15407 55 P
O'NEIL, ROBERT H, 901 GARFIELD,66606
354-9591
20 M 1902 45 IM
OBOURN, ROBERT L, 1150 OAKLEY,66604
273-7500
19 M 2802 50 P
OSOFSKY, HOWARD J, BOX 829,66601
273-7500
35 M 3515 58 P
OWEN III, JAMES W, 3457 JARDINE TERR,66611
234-3451
54 M 2802 79 DR

PALMBERG, KENT E. 901 GARFIELD.66606
354-9591
49 M 1902 74 IM
PARMAN, ROBERT D. 904 MULVANE.66606
232-8224
27 M 1902 54 PD
PARULKAR, DEEPAK S. 3511 SW MACVICAR.66611
-
49 M 49517 73 ANES
PASCUA, PERCIVAL G. BDX 829.66601
273-7500
39 M 74808 62 IM
PATEL, VINDD. 655 WESTCHESTER RD.66601
354-5174
47 M 49531 69 N
PATRICK, FRED EDWARD. 904 MULVANE.66606
232-8224
45 M 1902 71 PD
PAYNE, RDBERT R. 200 CDNTINENTAL MED BLDG.66606
233-7491
29 M 1902 55 DRS
PENN, GEDRGE M. VETERANS MEDICAL CENTER.66622
272-3111
30 M 4802 58 P
PERDUE II, W LANG. 631 HDRNE #400.66606
354-9504
49 M 1902 74 GS
PETERSDN, DEAN L. 308 MED ARTS BLDG WEST.66604
235-3451
24 M 1902 54 ANES
PETERSON, ROBERT L. STDRMDNT-VAIL EMERGENCY.66606
354-6108
36 M 1902 62 EM
PETERSDN, VERNON J. 310 MED ARTS BLDG.66604
234-3451
42 M 512 68 R
PETRIK, EDWIN L. MEMDRIAL HDSPITAL.66607
354-5164
35 M 1902 64 IM
PETTERSDN, DENNIS CRAIG. 310 MEDICAL ARTS BLDG.66604
234-3451
49 M 1902 74 R
PFUETZE, ROBERT E. 209 MED ARTS BLDG EAST.66604
232-3332
09 M 1902 35 OBG
PIERCE, CHARLES F. 918 W 10TH.66604
235-6282
24 M 4101 51 DBG
PIERCE, ODNALD R. 307 MED ARTS BLDG EAST.66604
235-2226
23 M 5101 49 FP
PDLLY, RICHARD E. 909 MULVANE.66606
357-0301
42 M 1803 68 DRS
PDRTER, RDBERT D. 901 GARFIELD.66606
354-9591
41 M 2802 67 IM
PDWELL, WILLIAM R. 833 GARFIELD.66606
233-8941
30 M 1902 54 GS
PDWELL II, BENSDN M. 400 CDNTINENTAL MED BLDG.66606
354-9504
26 M 1606 49 TS
PRESTDN, RALPH R. I710 WEST 10TH.66604
234-2624
19 M 1902 44 DPH
PRICE JR, LAURANCE W. 600 SE MADISON.66607
842-2083
33 M 1902 59 PATH
PRDCHASKA, MARK L. 5316 SW 10TH #301, 66604
273-7500
57 M 1902 84 P
PRDKOP, BRADFORD S. 920 SW WASHBURN.66606
233-3900
32 M 1606 57 DPH
PYLE, LUCIEN R. 3139 CANTERBURY LN.66604
-
DI M 1601 28 DBG
RAINBOW-EARHART, KATHRYN A. 2916 KENTUCKY.66605
233-1730
2I F 4707 48 P
RAJU, A S PADMA. 918 W 10TH.66604
234-3211
39 M 49509 61 TS
RAMSAY, GRACE A. B00 LINCDLN.66606
233-5105
48 F 1902 B0 OBG
RAMSEY, BARTLETT W. 904 MULVANE.66606
232-8224
25 M 1902 50 PD
RANDALL, GDRDDN R. 1001 HORNE SUITE 310.66604
234-3451
50 M 4706 78 R
RANSDELL, EDGAR C. 800 LINCOLN.66606
233-5101
41 M 3005 66 DBG
RANSDM, JAMES H. MEDICAL PLAZA BLDG.66604
234-2663
36 M I803 62 A
REINKING, VICTOR E, 631 HORNE SUITE 110, 66606
233-5084
26 M 1902 51 IM
REYMDND, RALPH D. S-F CAP REG RADIDTHER CTR.66606
295-8008
37 M 2301 67 R
RICCI, RDBERT LAWLER. 901 GARFIELD.66606
354-9591
50 M 1902 75 IM
RICH, JDSEPH E. WDMEN'S HEALTH CTR.66606
233-2700
47 M 40921 74 OBG
RICHARDSDN, J M. 634 SW MULVANE #404.66606
232-7762
47 M 1611 74 IM
ROBERTS, WARREN E. PD BDX 4047.66604
272-5797
25 M 1902 57 FP
RDBINSDN, DAVID B. 800 LINCOLN.66606
233-5101
47 M 1902 73 DBG
RDEDER, RDBERT E. 901 GARFIELD.66606
354-9591
40 M 1902 67 IM
RDEMBACH, JEANINE L. BDX 829.66601
273-7500
52 F 1902 75 CHP
RDSS, JACK L. MENNINGER FD.66601
273-7500
32 M 4812 56 P
RDTERT, LARRY. 301 MEDICAL PLAZA BLDG.66604
233-4256
38 M 3005 66 U
ROY, WILLIAM R. 634 MULVANE STE 104.66606
233-1979
26 M 1606 48 ADM
RUNNELS, JOHN B. 901 GARFIELD.66606
357-6171
35 M 1902 61 NS
RUPP, RICHARD J. 901 GARFIELD.66606
354-9591
42 M 3841 68 CD
SAMPAT, PRAVIN. 2707 WEST 29TH.66614
272-8440
51 M 49596 74 IM
SANCHEZ, ROGELIO. 1516 W 6TH ST.66606
232-1005
31 M 64901 64 U
SARGENT, JDSEPH D. MENNINGER FD.66601
273-7500
32 M 2501 58 IM
SAYLDR, EDWARD H. 918 WEST 10TH.66604
233-3362
39 M 1902 65 PD
SAYLDR, LESLIE L. 918 WEST 10TH.66604
-
07 M 1606 35 DO
SAYLDR, MARK. 918 WEST 10TH.66604
234-3211
37 M 1902 66 GS
SAYLDR, STEPHEN. 631 HDRNE SUITE 340.66606
232-9394
47 M 1902 73 FP
SCAMMAN, W WIKE. PD BDX C-50.66601
234-8621
32 M 4705 57 PATH
SCHLDESSER, HARVEY L. 918 MERCHANTS NATL BK.66612
235-3184
21 M 3901 51 P
SCHLDESSER, PATRICIA T. 1914 WARNER CT.66604
862-9360
24 F 3901 49 PD
SCHMIDT, MICHAEL J. 631 HDRNE APT 200.66606
233-7491
54 M 1902 76 DRS
SCHRAM, PETER CHARLES. PD BDX 829.66601
273-7500
39 M 2507 69 P
SEGERSON, JDHN A. 901 GARFIELD.66606
357-6171
I8 M 3545 43 N
SEHDEV, JDAN. 1001 HORNE SUITE 303.66604
233-3553
40 F 6101 63 FP
SETTLE SR, RUSSELL D. 1208 SW 29TH TER APT S25.66611
-
04 M 1902 29 DD

SHAW, JOSEPH L, 1001 HORNE SUITE 204, 66604
235-6221
34 M 511 60 ORS

SHEAFOR, DOUGLAS, 925 WESTERN,66606
233-7138
34 M 1902 60 P

SHELTON, STEPHEN E, 925 WESTERN,66606
233-7138
35 M 702 61 P

SHERWOOD JR, CLARENCE E, CONTINENTAL MED BLDG,66606
354-9504
22 M 702 53 GS

SHEU, W ERIC, 1001 HORNE SUITE 308,66604
235-3451
43 M 38505 67 ANES

SIMPSON, WILLIAM S, MENNINGER FOUNDATION,66601
273-7500
24 M 6001 48 P

SISK, PHILLIP B, 310 MED ARTS BLDG WEST,66604
234-3451
?? M 1803 56 R

SMITH, LEO A, 4201 SW EMLAND DR # 2,66606
-
08 M 3006 33 OO

SNARR, JACK W, MED ARTS BLDG W #310,66604
234-3451
41 M 6201 65 OR

SOHN, YUNGGYO, 6130 SW 26TH,66614
232-8761
40 M 58304 66 ANES

SPEARMAN, JESSE L, MED ARTS BLOG ROOM 24,66604
234-2879
20 M 1902 54 OBG

SPENCER, MILLARD C, 310 MED ARTS BUILDING,66604
234-3451
28 M 1902 55 R

SPENCER, WAYNE E, 103 MED ARTS BLDG EAST,66604
233-9686
38 M 1902 64 GE

STEIN, JOSEPH M, 901 GARFIELD,66606
357-6171
24 M 3519 47 N

STOCK, KARL W, 2740 BURLINGAME RD,66611
-
13 M 2834 37 OO

SUFI, M ASHRAF, 634 MULVANE #201A,66604
354-8518
43 M 70402 68 IM

SWOGGER JR, GLENN, MENNINGER FD,66601
273-7500
35 M 3806 60 ?

TAPPEN, DANIEL L, 2333 MAYFAIR PL,66611
-
16 M 1902 41 OO

TARGOWNIK, KARL K, 1218 W TENTH,66604
232-1644
15 M 40710 49 P

TARNOWER, AMY C, 2112 CREST DR,66614
-
58 F 1902 85

TARNOWER, WILLIAM, MENNINGER CLINIC,66601
273-7500
21 M 4802 48 P

TEMPERO, STEPHEN J, 310 MED ARTS BLOG,66604
234-3451
42 M 1606 67 R

THOMS, NORMAN W, 40 MED ARTS BLDG,66604
233-1710
34 M 2501 59 TS

THURSTON, DAVID E, 200 CONTINENTAL BLDG,66606
233-7491
29 M 1902 55 ORS

TIETZE, DENNIS O, 634 MULVANE STE 402,66606
235-9545
50 M 1902 78 FP

TOTH, JOHN ROY, 2115 W TENTH,66604
232-3330
49 M 1902 71 FP

TOZER, RICHARD C, 1447 OAKLEY,66604
-
19 M 4102 45 OO

TRAVIS, JOHN W, S-F CAP REG RADIOTHER CTR,66606
295-8008
29 M 1606 55 R

TREGER, NEWMAN V, 1704 W 10TH,66604
354-8761
16 M 1902 40 IM

TUCKER, VIRGINIA L, BUREAU OF MAT & CHILD HLT,66620
862-9360
30 F 1902 57 PD

TWEMLOW, STUART W, 5040 SW 28TH,66614
233-1607
41 M 67101 73 ?

UHR, NATHANIEL, MENNINGER FOUNDATION,66601
273-7500
00 M 3519 21 IM

VAN SICKLE, GREGGORY J, 634 MULVANE,66606
233-8508
49 M 1606 75 PD

VANDE GARDE, LARRY D, 800 LINCOLN,66606
233-5101
41 M 1803 66 OBG

VOGEL, STANLEY J, 901 GARFIELD,66606
354-9591
44 M 2802 70 ON

VOTH, ERIC A, 901 GARFIELD,66606
354-9591
55 M 1902 81 IM

WADE III, WILLIAM E, D.O., 1115 W 10TH STE A, 66604
233-8268
53 M 3979 80 FP

WALIA, JAG M, 2200 W 10TH, 66604
232-6850
50 M 49515 72 FP

WALLACE, LEO F, 5500 W 24TH,66614
-
17 M 1902 41 OO

WALLS, WILLIAM J, 310 MED ARTS BLDG,66604
234-3451
39 M 2834 66 OR

WALZ, ROYCE C, 1710 W 10TH SUITE 205,66604
234-2676
27 M 15407 60 ?

WALZ, THOMAS J, C/O RDYCE WALZ,66604
-
94 M 1902 21 OO

WANLESS, KIRK M, 1424 W EIGHTH,66606
232-8188
44 M 2803 74 OTO

WARD, HOWARD N, 901 GARFIELD,66606
354-9591
37 M 1606 62 HEM

WARE, LUCILE M, MENNINGER FOUNDATION,66601
273-7500
29 F 3501 53 ?

WARRICK, DAVID ALAN, 600 MADISON,66607
354-5275
49 M 3843 76 IM

WATERS, DALE A, 634 SW MULVANE SUITE 203,66606
233-1690
41 M 5605 67 CDS

WEAVER, WALTER D, 900 WASHBURN ST,66605
233-3636
41 M 1902 69 DPH

WEBER, DARRELL J, 1710 W 10TH,66604
233-2305
16 M 1902 44 FP

WELSH, NANCY JANE, 600 SE MADISON,66607
354-5354
39 F 3840 63 IM

WILCOX, DONALD E, 122 DANBURY LANE,66606
296-3782
24 M 1902 55 PH

WILSON, MARVIN H, 1516 SW SIXTH,66606
233-1747
38 M 1003 64 GS

WOOD, EDWARD RUSSELL, 901 GARFIELD,66606
354-9591
49 M 1902 71 IM

WOODS, ROBERT P, 901 GARFIELD,66606
357-6171
14 M 6701 40 N

YEH, ROBERT M, 2315 W 34TH,66611
235-3451
47 M 24405 73 ANES

YORKE JR, CRAIG H, 901 GARFIELD,66606
357-6171
48 M 2401 74 NS

YOUNG, PAUL E, TOPEKA MED CTR, 66604
233-4927
42 M 2407 75 OPH

YOUNG, THEODORE E, 631 SW HORNE #310,66606
232-0576
22 M 2307 46 PD

ZACHARIAS, DAVID LLOYD, 1500 W TENTH,66606
354-6870
26 M 1902 53 PATH

ZIMMERMAN, WILLIAM H, CONTINENTAL BLDG,66606
232-4377
20 M 3006 52 GS

TOWANDA — 316
(Sedgwick County Society)

NYBERG, FREDRIK F, ROUTE 1,67144
-
22 M 2101 46 OO

TRIBUNE—316
(Southwest Kansas Society)

WERNER, WILLARD F, ,67879
376-4251
24 M 1902 52 FP

TROY—913
(Northeast Kansas Society)

MASTERSON, MELVIN LEROY, 210 S MAIN,66087
785-2211
23 M 4901 48 R

ULYSSES—316
(Southwest Kansas Society)

BREWER, MARSHALL A, PO BOX 687,67880
356-1261
19 M 1902 46 FP
RAMCHANDANI, A P, 301 E GRANT,67880
356-2432
39 M 49530 74 FP
TILLOTSON, DON R, BOX 687,67880
356-1261
32 M 1902 65 FP

VALLEY CENTER—316
(Sedgwick County Society)

DANIELS, ROBERT M, BOX 128,67147
838-2794
24 M 1902 54 FP
WILSON, ROBERT L, RR 1,67147
685-2563
30 M 1902 57 EM

WAKEENEY—913
(Central Kansas Society)

HAMILTON, JAMES J, MEDICAL CENTER,67672
743-2124
30 M 1902 55 FP

WAMEGO—913
(Pottawatomie County Society)

BORGENDALE, LLEWELLYN V, 507 ELM,66547
456-2291
29 M 1902 60 FP
BRADEN, BILL L, PO BOX 7,66547
456-2291
31 M 1902 60 FP
CLARK, LAURENCE A, 507 ELM,66547
456-2291
12 M 1902 42 FP
WELCH, MAURA S, BOX 149,66547
456-9202
50 F 1902 75 OBG
WIGGLESWORTH, ANNE, HWY 24 PO BOX 149,66547
456-9202
40 F 1902 75 OBG

WASHINGTON—913
(Northeast Kansas Society)

HODGSON, DAVID K, 107 E THIRD,66968
325-2259
49 M 1902 78 FP

WATHENA—913
(Northeast Kansas Society)

PETERSON JR, EVAN A, 324 ST JOSEPH ST,66090
989-3122
24 M 1803 55 FP

WELLINGTON—316
(Tri-County Society)

ANDERSON, LARRY R, 1323 NORTH A,67152
326-3301
43 M 1902 73 FP

COLE, WARD M, 110 N JEFFERSON,67152
326-7221
08 M 1902 36 FP
NALOOZA JR, FAUSTINO M, 1323 NORTH A,67152
326-8171
M 74801 64 GS
PEORAZA, HERNANDO, 33 CRESTWAY,67152
326-8070
28 M 26404 56 R
WEIGAND, JOEL T, 1323 NORTH A,67152
326-3301
43 M 1902 70 FP

WESTMORELAND—913
(Pottawatomie County Society)

DECHAIRO, THOMAS, DECHAIRO HOSP,66549
457-3311
13 M 1902 36 FP

WICHITA—316
(Sedgwick County Society)

ABBAS, DILAWER H, 1515 S CLIFTON APT 360,67218
686-2831
45 M 70402 71 N
ACEVEDO, ALFREDO, 959 N EMPORIA SUITE 205,67214
265-4701
40 M 73701 59 CDTS
AGUSTIN, CONRADO M, 103S N EMPORIA STE 165,67214
267-3389
38 M 74807 62 OBG
AHLSTRAND, RICHARD A, 3243 E MURDOCK SUITE 104,67208
685-2711
41 M 3005 67 R
ALDOROTY, NEIL, 3243 E MURDOCK STE 400,67208
686-7351
46 M 64914 75 P
ALEXANDER, ELIZABETH, UKSM-WICHITA, 67214
685-8231
46 F 1902 77 FP
ALFONSO, MANUEL, 3311 E MURDOCK,67208
689-9445
37 M 84710 66 ANES
ALLEN, PHILLIP M, WESLEY MEDICAL CENTER,67214
688-2838
27 M 2401 54 PATH
ALMONTE, PRISCILLA C, 758 S HILLSIDE SUITE 1,67211
684-7251
44 F 74801 67 ANES
ALMONTE, RODOLFO O, 151S S CLIFTON SUITE 480,67218
686-3791
39 M 74801 64 OBG
AMMAR, ALEX O, 818 N EMPORIA SUITE 200,67214
263-0296
51 M 5101 76 GPVS
AMSTUTZ, SAMUEL W, 655 N WOODLAWN, 67208
684-5158
53 M 1601 80 OPH
ANDERSON, DAVID J, 3243 E MURDOCK STE 401,67208
686-7327
54 M 1902 81 ANES
ANDERSON, EUGENE G, SUTTON PLACE,67202
-
19 M 1902 44 OO
ARGOSINO, RODOLFO, 1148 S HILLSIDE,67211
683-6506
40 M 74801 63 GS
ARNOLD, KATHLEEN J, 6510 E 29TH,67226
-
55 F 1902 84
ARTZ, TYRONE D, 1125 N TOPEKA,67214
267-0362
41 M 1803 67 ORS
ASHMORE, ARTHUR L, 1441 N ROCK RD #906,67206
-
05 M 1902 32 OO
AUNINS, JOHN, 4853 HEMLOCK,67216
524-6805
28 M 4706 56 FP
BABER, JAMES W, C/O ANESTHESIOLOGY,67214
268-6147
59 M 1902 84 ANES
BACKES, DAVID J, 851 N HILLSIDE,67214
683-1371
48 M 1720 77 U
BAILEY, DONALD C, 3243 E MURDOCK,67208
685-1491
37 M 3901 65 ORS

BAMMEL, BRUCE, 3311 E MURDOCK,67208
689-9234
52 M 2507 78 OBG
BARBA, ESTRELLA G, 8430 HUNTINGTON,67206
264-2301
41 F 74802 66 CHP
BARBA JR, ANTONIO P, 1035 N EMPORIA STE 280,67214
264-2301
34 M 74807 62 OBG
BARKER, BENJAMIN W, 8015 WILLOWBROOK,67207
-
18 M 1902 51 DO
BARKER, MONTY R, 848 S CHAUTAUQUA,67211
-
57 M 1902 85
BARKER, PATSY, 818 N EMPORIA SUITE 303,67214
265-3774
49 F 64914 75 PD
BARNETT, ARNOLD M, 5111 E 21ST,67208
685-2561
32 M 83601 54 N
BARTAL, ELY, 818 N EMPORIA SUITE 306,67214
262-7598
45 M 39607 70 ORS
BARTLETT, WAYNE C, 13 HAMPTON RD,67207
689-9124
07 M 1601 31 GS
BASHAM, BRIAN E, 456 COURTLEIGH DR,67218
-
61 M 1902 88
BASINGER, BRADLEY B, 6747 PAR LN #1410,67212
-
53 M 1902
BASS II, ORAL E, 851 N HILLSIDE,67214
685-1371
40 M 2803 71 U
BASSELL, G M, 3333 E CENTRAL SUITE 602,67208
685-4389
46 M 14303 73 ANES
BATES, MICHAEL D, 2703 EAST CENTRAL,67214
585-6521
48 M 3005 74 OBG
BAUMAN, M LEON, 1629 UNIVERSITY,67213
-
01 M 1902 44 OD
BAUMANN, PAUL A, 3333 E CENTRAL,67208
688-2920
32 M 5605 57 R
BEAMER, LARRY R, 818 N EMPORIA SUITE 200, 67214
263-0296
52 M GS
BEARCE, SHARON K, 1945 N ROCK RD #7, 67206
--
58 F 1902 87
BEARDEN, DENNIS E, 544 N BROADVIEW,67208
-
59 M 1902 87
BEBAK, DONALD M, 2322 E CENTRAL,67214
263-6186
32 M 3515 58 ANES
BECK, CHARLES W, 1515 S CLIFTON STE 215,67218
687-9961
46 M 301 72 IM
BECKER, KARL E, 818 N EMPORIA STE 307,67214
264-9476
43 M 2307 69 ANES
BETHEL, CHANDLER S, 5107 E 21ST ST,67208
682-6559
34 M 1902 59 IM
BHARGAVA, BAIKUNTH N, 3243 E MURDOCK SUITE 102,67208
682-4523
37 M 49530 63 U
BIBERSTEIN, GREG A, 1739 LEXINGTON,67218
-
56 M 1902 84
BIERMANN, HENRY J, 425 E MURDOCK,67214
265-6287
27 M 3006 52 GS
BIERMANN, WILLIAM J, 1435 LIEUNETT,67203
-
04 M 3006 29 OD
BIGONGIARI, LAWRENCE R, 929 N ST FRANCIS, 67214
--
44 M 1611 69 R
BINGAMAN, ROBERT W, 7111 E 21ST,67206
682-1053
47 M 3901 72 GS
BINYON, KERNIE W, BOX 8125,67208
684-2819
24 M 1902 56 FP
BLAYLOCK, HOYT C, 835 N HILLSIDE,67214
-
21 M 1902 45 DO
BLOOM, RODNEY LAMONT, 406 E CENTRAL,67202
265-0705
54 M 1902 79 IM
BLOXHAM, THOMAS J, 3311 E MURDOCK,67208
689-9215
50 M 1803 75 PUD
BOCK, PETER A, PO BOX 969,67201
-
57 M 1902 84
BOEHM, DOUGLAS K, 3243 E MURDOCK SUITE 500,67208
684-0251
52 M 1902 77 IM
BOEHM, MINDY M, 3333 E CENTRAL SUITE 408,67208
682-0411
52 F 1902 78 PD
BOND, ROGER C, 3243 E MURDOCK,67208
684-0251
40 M 5606 67 CD
BOXBERGER, GREGORY R, 818 N EMPORIA,67214
264-8604
52 M 1902 78 CD
BOYD, Z REX, 120 S MAIZE RD #12,67209
268-5000
26 M 3005 52 FP
BOYLE, HUGH H, 424 N WOODLAWN,67208
686-2193
33 M 3806 60 PATH
BRAKE, DAVID, 3243 E MURDOCK SUITE 104,67208
685-2711
43 M 702 68 R
BRAUN, KENNETH, 1431 BLUFFVIEW STE 211,67218
683-4688
47 M 3519 72 OPH
BRAUN, THOMAS G, 3243 E MURDOCK #601,67208
685-2377
35 M 6001 61 N
BRAUN III, WILLIAM T, 3243 E MURDOCK SUITE 104,67208
685-2711
37 M 2802 61 R
BRECKBILL, DAVID L, 3333 EAST CENTRAL #214,67208
685-1291
38 M 1902 64 R
BRENNEIS, ANN T, 400 N CENTRAL APT 3115,67203
-
60 F 1902 86
BRINTON, E HOLMES, 3311 MURDOCK,67208
689-9124
46 M 2101 70 GS
BRINTON, EDWARD S, 5051 E LINCOLN #8A,67218
-
15 M 1611 41 OD
BRITO, RAUL E, 3243 E MURDOCK,67208
682-4523
32 M 31901 59 U
BROSIUS, FRANK C, 3243 E MURDOCK,67208
684-0251
25 M 1902 49 IM
BROWN, DAVID J, 425 EAST MURDOCK,67214
265-6287
45 M 1902 71 GS
BROWN, MICHAEL P, 345 N HILLSIDE,67214
683-6766
51 M 3007 77 OBG
BROWN, MICHELLE R, 2717 S MARTINSON,67217
-
56 F 1902 86
BROWN, ROBERT L, 5025 E KELLOGG,67218
682-1534
21 M 1902 49 FP
BROWN, RONALD C, 3243 E MURDOCK,67208
685-8231
47 M 2803 73 FP
BROWN, RONALD L, 1128 S CLIFTON,67218
684-7251
45 M 3901 71 ANES
BROWN, VAL J, 1802 N HYDRAULIC,67214
265-1461
24 M 1003 47 FP
BROWN JR, VAL J, 1802 N HYDRAULIC,67214
265-1461
53 M 1902 79 IM
BROWNING, WILLIAM H, 7077 E CENTRAL #17,67206
-
16 M 1902 43 DO
BUBECK, RALPH W, 3311 E MURDOCK,67208
689-9396
36 M 1803 62 IM
BUCK JR, BEN H, 1515 S CLIFTON SUITE 480,67218
684-1048
17 M 2834 43 TS
BULLER, DAVID L, 708 S RUTAN,67218
-
58 M 1902 85
BURNEY, WILLIAM W, 1755 N MADISON,67214
264-8311
17 M 1902 52 FP

BURNEY II, WILLIAM W, 1755 N MADISON,67214
264-8311
50 M 4707 76 IM
BURPEE, JAMES F, 851 N HILLSIDE,67214
685-1371
39 M 5605 66 U
BURT, RONALD J, 1628 52ND NW,67204
-
47 M 1902 84
BUTH, DENNIS K, 2916 EAST CENTRAL,67214
684-5243
45 M 1902 72 IM
BUTIN, J WALKER, 3311 E MURDOCK,67208
689-9477
23 M 1902 47 IM
BUTLER, DORIS C, 1148 S HILLSIDE,67211
684-2329
48 F 1902 75 FP
BYRNE, JAMES PERRY, 818 N EMPORIA SUITE 200,67214
263-0296
42 M 2101 68 TS
CALIENDO JR, DANIEL J, WESLEY MED CENTER,67214
685-2563
41 M 1902 67 EM
CAMPION, MARY K, UKSM WICHITA,67214
261-2650
51 F 1902 80 IM
CANNON, DONALD C, 5400 E 21ST APT 108,67208
-
34 M 1602 60 IM
CANNON, MICHAEL W, 1035 N EMPORIA SUITE 265,67214
588-6029
50 M 1902 75 ON
CAPPER, STANLEY L, 3311 E MURDOCK,67208
689-9206
37 M 1803 67 D
CARLSON, TERRY S, 550 N HILLSIDE,67214
688-2820
50 M 3006 77 PATH
CARRO, TONY L, BOX 314, 66549
--
57 M 1902
CASTELLANI, SAM, UKSM WICHITA PSY DEPT,67214
261-2647
41 M 2507 67 P
CASTERLINE, JOHN B, 1010 APACHE,67207
-
62 M 1902 88
CATO, TERI A, 9000 E LINCOLN #703
--
60 F 1902 87
CAUBLE, WILBUR G, 1148 S HILLSIDE SUITE 102,67211
683-1681
12 M 2834 39 GS
CAUGHLIN, GERALD MICHAEL, 818 N EMPORIA SUITE 101,67214
263-1574
55 M 4812 80 ANES
CAWLEY, LEO P, WESLEY MED CENTER,67214
688-2836
22 M 3901 52 PATH
CHANEY, ERNIE J, ST JOSEPH MED CENTER,67218
689-5500
27 M 1902 56 FP
CHANG, FREDERIC C, 818 N EMPORIA SUITE 200,67214
263-0296
35 M 2401 59 GS
CHAPMAN, JAMES H, PO BOX 8128,67208
265-1684
27 M 4706 63 R
CHARO, FREDERICK H, 3244 E DOUGLAS,67208
-
15 M 5605 39 OO
CHATMAN, IRA DOUGLAS, 831 LITTLEFIELD,67003
-
53 M 2803 75
CHI, IL-SUNG, 3333 E CENTRAL STE 602,67208
685-4389
41 M 58302 67 ANES
CHO, SECHIN, UKSM - WICHITA,67214
261-2631
47 M 58302 71 PD
CHOPRA, RAMAN, 3333 E CENTRAL #201,67208
685-5271
52 M 49536 76 PD
CHRISTMAN JR, CARL, 550 N LORRAINE,67214
685-0559
48 M 4802 74 OBG
CLARK, COURTNEY, 758 S HILLSIDE #1,67211
684-7251
30 M 1902 56 ANES
CLIFTON, H DAVID, 3600 E HARRY,67218
689-5050
41 M 401 65 R
CLINE, BYRON W, 550 N LORRAINE,67214
685-0559
51 M 4802 77 OBG

COBB, JEANNINE M, 1720 PARK PLACE,67203
-
48 F 1902 88
COHEN, JUSTIN THOMAS, 655 N WOODLAWN,67208
684-5158
47 M 2803 74 OPH
COHLMIA, JERRY B, 818 N EMPORIA SUITE 310,67214
263-5891
43 M 1902 70 IM
COLEMAN, THOMAS J, 959 N EMPORIA,67214
265-0749
18 M 3545 51 IM
COLLIER, HAROLD W, 1515 S CLIFTON SUITE 260,67218
683-5008
45 M 1902 71 ANES
CONCANNON, CRAIG A, 8143 E INDIANAPOLIS,67207
-
58 M 1902 84
CONCEPCION JR, EUGENIO S, 1515 S CLIFTON SUITE 480,67218
684-1048
39 M 74802 64 CD
CONRAROY, PETER A, 818 N EMPORIA #101,67214
683-1574
42 M 515 69 ANES
COOK, DONALD RAY, 315 N HILLSIDE,67214
686-3392
42 M 2012 71 FP
COOK, G EDWARD, ST JOSEPH HOSPITAL,67218

COOK, KAROLYN M, 3232 S CLIFTON #439, 67216
--
61 F 1902 87
COOK, THEODORE R, 3232 S CLIFTON #439,67216
-
61 M 1902 87
COOPER, M KENT, 818 N EMPORIA STE 307,67214
264-9476
54 M 1902 79 ANES
CORORY, VINCEL R, O.O., 1512 MAYBELLE,67212
-
47 M 2878 75 P
CORONADO, EDWARD H, 1717 S CYPRESS APT 1524,67207
-
51 M 74808 76 P
COSSMAN, F PRICE, 851 N HILLSIDE,67214
685-1371
28 M 1902 57 U
COWLES, GORDON T, 3333 E CENTRAL,67208
683-2661
32 M 1902 58 OBG
CRANE, DAVID O, 929 N ST FRANCIS,67214
268-5414
34 M 2501 60 PATH
CRONIN, DONALD J, 3311 E MURDOCK,67208
689-9227
16 M 2604 40 ENT
CROW, ERNEST W, 3243 E MURDOCK,67208
684-0252
20 M 1902 44 CD
CROWLEY, EDWARD X, 345 N HILLSIDE,67214
-
14 M 1643 39 OO
CUMMINGS, RICHARD J, 427 N HILLSIDE,67214
686-6608
32 M 1902 57 OTO
CZAPANSKY, DESIREE K, 3425 E PINE,67208
-
59 F 1902
OAKHIL, SHAKER R, 818 N EMPORIA SUITE 403,67214
262-4467
50 M 60501 75 IM
OANBY, JOHN H, 905 N EMPORIA,67214
265-2876
29 M 35205 56 FP
DANSOILL, DAVID J, 439 N LORRAINE,67214
687-2209
M 1902 85
DARRAH, JOY N, 144 S HILLSIDE,67211
685-3411
49 F 1902 74 R
DAVIDSON, HARRY T, 556 N BROADVIEW,67208
-
87 M 3802 11 OO
DAVIS, DANIEL R, WESLEY MEDICAL CENTER,67214
688-2800
44 M 3901 70 PATH
DAVIS, PAUL H, 7111 E 21ST,67206
684-2851
47 M 3901 72 FP
DAVIS, RONALD B, 2405 E PAWNEE #10,67211
685-2153
46 M 1902 72 FP
DAVISON, JOE O, 8200 W CENTRAL #1,67212
722-5001
54 M 3901 76 FP

DAY, HOWARD, 818 N EMPORIA SUITE 310,67214
263-5891
48 M 1902 74 NEP
DE BAKKER, JAN B, 103S N EMPORIA,67214
263-4903
25 M 5104 59 GS
DE HART, ARTHUR DONIVA, 2703 E CENTRAL,67214
685-1277
S0 M 4804 77 OBG
DEGNER, JAMES C, 4901 ARLENE,67220
-
57 M 1902 84
DEJONG, DAVID C, PO BOX 12667,67279
268-5424
33 M 2501 59 PATH
DEMOSS, ELEANOR P, 3333 E CENTRAL SUITE 407,67208
682-5591
42 F 74802 66 PD
DIAZ, DOLORES M, 3333 E CENTRAL SUITE 602,67208
685-4389
51 F 64902 75 ANES
DIAZ, SALVADOR F, 3333 E CENTRAL STE 602,67208
685-4389
45 M 64902 73 ANES
DIRKSEN, HANS C, S50 N HILLSIDE,67214
688-2360
47 M 6001 71 NEO
DOEBLIN, P LAURENCE, 3333 E CENTRAL SUITE 214,67208
685-1291
40 M 1002 73 R
DOLAN JR, PHILIP JARVIS, 3311 E MURDOCK,67208
689-9241
47 M 2105 73 GE
DONATELLE, EDWARD P, UKSM WICHITA,67214
261-2607
22 M 2604 S0 FP
DONLEY, JAMES L, 3101 E NINTH,67208
684-0201
46 M 1902 72 P
DONNELL, JAMES M, 2320 E CENTRAL,67214
264-8010
28 M 1902 5S FP
DOORNBOS, J FRED, 929 N ST FRANCIS,67214
268-5908
28 M 1902 S7 R
DOUGHERTY JR, THOMAS M P, 343 N HOLYOKE,67208
-
S6 M 1902
DOUTHIT, DOUGLAS DAVID, 5S0 N LORRAINE,67214
685-0SS9
S3 M 4802 79 OBG
DRAKE, RALPH L, 4422 E 3RD,67208
-
99 M 4102 26 OD
DRAZEK, GEORGE, 3311 E MURDOCK,67208
689-9316
50 M 3506 76 OPH
DREVETS, CURTIS C, 3311 E MURDOCK,67208
689-9178
30 M 1902 S6 IM
DUGAN, DAVID L, 331 N ERIE, 67214
--
56 M 1902 87
DUICK, GREGORY, PO BOX 47669,67201
265-1308
46 M 1643 72 CD
DUNSHEE, CHERYL A, UKSM WICHITA,67214
261-2650
S4 F 1902 79 IM
DURAND, ANTONIO C, 9S9 N EMPORIA,67214
263-7893
29 M 74807 S6 U
DYER, VERNON E, 3311 E MURDOCK,67208
689-9234
36 M 301 72 OBG
ECK, MARCI J, 327 N GREEN,67219
-
S9 F 1902 86
ECKERT, WILLIAM G, 7006 E TENTH,67206
685-7612
26 M 3519 S2 PATH
EDWARDS, MANIS C, 3333 E CENTRAL,67208
683-2661
33 M 300S 58 OBG
EGBERT, ANNE MARSH, UKSM WICHITA,67214
261-2650
S4 F 3840 79 IM
EGELHOF, RICHARD H, 3311 E MURDOCK,67208
94S-0142
4S M 1902 73 FP
ELANGOVAN, SUDHA, 14033 E GILBERT, 67230
--
45 F 1902 87

ELLIS, HARVEY D, 6611 E CENTRAL,67206
683-1022
24 M 1902 SS GS
ELLIS, LAVELLE A, S50 W CENTRAL SUITE 1114,67203
-
60 F 1902 86
ENOCH, ROLLAND, 31S N HILLSIDE,67214
681-0423
49 M 64914 76 FP
ERKEN, RONALD V, WICHITA PSYCHIATRIC CTR,67208
684-0201
29 M 2834 S6 P
ERNST, R L, 803 FRANKLIN,67203
-
S6 M 300S 82 GS
ERNST, TARI MAE, 1010 N KANSAS,67214
251-2622
S6 F 300S 81 FP
ESTEP, THOMAS H, 818 N EMPORIA SUITE 200,67214
263-0296
S1 M 6002 75 CO
EVANS, FARRIS D, S21 RUTLAND RD,67206
-
0S M 1902 32 OO
EVANS, GRANT E, 2703 E CENTRAL,67214
682-6556
21 M 4901 46 FP
EVANS, JOHN F, 5826 POLO,67208
688-2360
42 M 2803 70 MFM
EVANS, RICHARD W, 1431 S BLUFFVIEW,67218
68S-3030
S1 M 5107 76 IM
EVANS, ROGER WILLIAMS, 3311 E MURDOCK,67208
263-5889
39 M 1902 64 CD
EYSTER, ROBERT L, 3243 E MURDOCK,67208
68S-1491
47 M 3901 73 ORS
FARHA, GEORGE J, 818 N EMPORIA SUITE 200,67214
263-0296
27 M 2101 57 GS
FARHA, S JIM, 818 N EMPORIA SUITE 200,67214
263-0296
31 M 1001 57 TS
FARLEY, JAMES A, ST JOSEPH MEDICAL CENTER,67218
689-S671
S0 M 1902 78 PATH
FEAREY, ALAN J, 3311 E MURDOCK,67208
689-9410
S3 M 1902 78 IM
FENDER JR, THOMAS H, 3432 EVERETT,67217
267-8439
2S M 4812 S4 NP
FERRELL, DONALD P, ST JOSEPH MEDICAL CTR,67218
689-S775
36 M 3901 63 EM
FERRIS, BRUCE G, 82S N HILLSIDE,67214
688-7S00
43 M 1902 69 PS
FEUILLE JR, EDMOND G, 212 N HILLSIDE,67214
682-4572
S0 M 4802 7S OBG
FIELDS, STEPHEN, D.O., 7200 W 13TH,67212
721-1200
42 M 2878 72 FP
FINLEY, DENNIS R, 103S N EMPORIA,67214
262-7429
36 M 1606 62 ORS
FISHER, JAMES B, 141 S OLD MANOR,67218
-
09 M 1902 36 OO
FISHER, RAY F, 3243 E MURDOCK SUITE 500,67208
684-02S1
49 M 1902 74 IM
FITZGERALD, EDWARD J, 3600 E HARRY,67218
689-50S0
22 M 3006 50 R
FITZIG, SANFORD, 3311 E MURDOCK,67208
689-9344
46 M 4102 72 U
FLEMING, FORNEY W, 3243 E MURDOCK #200,67208
68S-1491
43 M 4802 69 ORS
FLOWERS JR, CLELL B, 8S5 N HILLSIDE,67214
68S-1381
22 M 1902 SS FP
FORD, CHARLES R, 232 S MAIZE RD,67209
722-0S68
38 M 1902 63 OPH
FOWLER, ROBERT J, 3311 E MURDOCK,67208
689-9236
37 M 2802 63 IM

FRANCIS, NORTON L, 55 VIA ROMA,67230
-
10 M 3005 35 ENT
FRANCISCO, DAN A, 3243 MURDOCK SUITE 500,67208
684-0251
40 M 1803 75 CO
FRANCISCO, LINDA L, 818 N EMPORIA SUITE 310,67214
263-5891
47 F 1803 74 NEP
FRENCH, JAMES E, 1515 S CLIFTON #420,67218
684-5237
53 M 3005 78 GS
FRENCH, JEROME E, MID-KANSAS ENT ASSOC,67211
684-2838
44 M 1103 71 OTO
FRITZEMEIER, WILLIAM H, 835 N HILLSIDE,67214
685-4395
14 M 1902 41 O
FROMER, JOEL, 2627 E CENTRAL,67214
684-0501
46 M 16501 75 A
FROMM, ARTHUR H, 315 N HILLSIDE,67214
685-2281
37 M 1902 63 FP
FUGATE, CARL L, 2248 PATTIE,67211
264-7595
57 M 1902 84
FULTON, JOHN K, 236 S TERRACE,67218
-
18 M 5605 43 OO
GALICHIA, JOSEPH P, 818 N EMPORIA BOX 47668,67201
264-8604
42 M 1902 69 CO
GALVAN, ALONSO, 3243 E MURDOCK,67208
684-0251
38 M 64906 64 IM
GARO, RAYMOND F, 7077 E CENTRAL #25,67206
-
01 M 1902 27 GS
GEARY, ALICE L, 3311 E MURDOCK, 67208
689-9655
50 F 401 80 IM
GENILO, AMANCIO C, 1520 S CLIFTON,67218
689-5775
37 M 74801 61 EM
GENILO, CELESTE A, 3311 E MURDOCK,67208
689-9445
39 F 74801 62 ANES
GEORGE, EARL F, 5107 E 21ST,67208
681-3320
35 M 1902 65 FP
GEORGE, M DON, UKSM WICHITA,67214
684-0201
31 M 1001 56 P
GERBER, ALLEN O, 7111 E 21ST,67206
682-1053
48 M 1902 71 GS
GILLENWATER, DAVID T, 14315 WAKANDA CT,67230
-
60 M 1902 86
GILMARTIN, RICHARD C, 3243 E MURDOCK #601,67208
685-2377
32 M 4112 58 PDN
GIVNER, DAVID, 2627 E CENTRAL,67214
-
03 M 2301 29 OO
GOERING, RANDALL V, 401 S LORRAINE,67211
-
58 M 1902 84
GOLDBERG, HERBERT R, 3 PARK AVE,67206
261-2631
33 M 3508 59 PD
GONZALEZ, HIRAM, 3429 E DOUGLAS,67218
681-1348
20 M 64901 52 P
GOODPASTURE, HEWITT C, 818 N EMPORIA SUITE 305,67214
264-3505
43 M 1902 69 IM
GORDON, JAMES R, 3311 E MURDOCK,67208
689-9260
53 M 1611 78 IM
GORTON, MICHAEL E, 1945 N ROCK RD #1411,67206
687-5935
61 M 1902 86
GOYLE, KRISHAN K, 1144 N ST FRANCIS,67214
267-0159
34 M 49529 63 CO
GOYLE, VIMAL, 1150 N ST FRANCIS,67214
267-9906
41 F 49529 65 OBG
GRAUEL, CHARLES W, 8310 CHALET,67207
684-6215
44 M 1902 70 ANES
GRAVES, JACK W, 610 RUTLAND,67206
-
17 M 1902 42 OO

GRAY, C LUCIEN, 4821 E CENTRAL,67208
684-5171
21 M 1902 45 ENT
GRAY, H TOM, 3610 E ENGLISH 1028,67218
-
19 M 401 44 OO
GREENBERG, CRAIG P, 3311 E MURDOCK, 67208
689-9373
56 M 1643 80 END
GREENWOOD, MELANIE A, 1402 BURNS,67203
-
49 F 1902 88
GREER, JAMES A, 3311 E MURDOCK,67208
689-9227
43 M 1611 69 OTO
GRELINGER, BART A, 3609 E KELLOGG DR, 67218
--
M 1902 87
GRENE, ROBERT BRUCE, 655 N WOODLAWN,67208
684-5158
53 M 1902 78 OPH
GRIBBLE, ROBERT N, PO BOX 47668,67214
264-2401
43 M 1902 69 R
GRILLOT, FLOYD B, 1515 S CLIFTON SUITE 150,67218
684-0243
18 M 1902 51 FP
GROHS, HEINZ K, 550 NORTH HILLSIDE,67214
685-2151
42 M 15407 66 PATH
GRUSHNYS, ARNOLD, 3311 E MURDOCK,67208
689-9445
19 M 40721 59 ANES
GSELL, GEORGE F, 32 MISSION RD,67206
-
07 M 1601 33 OO
GUTHRIE, RICHARD A, 1515 S CLIFTON, 67218
264-6310
35 M 2803 60 PD
HABASHY, SHAWKY N F, 905 N EMPORIA,67214
265-2876
43 M 33004 65 OBG
HAGAN, C THOMAS, UKSM WICHITA,67214
265-0789
16 M 3006 42 IM
HAGAN, FRANCIS J, PO BOX 1837,67201
262-1057
13 M 3006 39 FP
HAGAN, ROBERT C, 3311 E MURDOCK,67208
-
52 M 1902 77 OO
HAGAN, STEPHEN F, 1250 W MAPLE,67213
262-1057
53 M 2802 80 PUD
HALE, RALPH, 2627 E CENTRAL,67214
-
18 M 1902 46 OO
HALL, J ROGER, 1515 S CLIFTON SUITE 310,67218
685-5227
42 M 4802 68 OPH
HALPIN, EDWARD O, 1148 S HILLSIDE,67211
685-9229
33 M 1902 62 OBG
HAM, ROBERT E, 343 N HOLLYOKE,67208
-
53 M 1902 86
HANSON, ROBERT L, 6202 ONEIDA,67208
-
59 M 1902 86
HARMS, EDWIN M, 5623 POLO DR,67208
-
06 M 3901 34 OO
HARRIS, FRANK H, 1035 N EMPORIA,67214
262-1853
09 M 1001 39 NP
HARRISON, PAUL BARRY, 3243 EAST MURDOCK,67208
685-6222
49 M 1902 74 GS
HARSTINE, LILLIAN R, 2501 E CENTRAL,67214
682-6585
51 F 1902 76 IM
HART, DILLIS L, 1515 S CLIFTON SUITE 300,67218
688-0135
36 M 3901 64 GS
HART, JOHN J, 3243 E MURDOCK SUITE 303,67208
688-3070
53 M 74808 60 GP
HARTLEY, JAMES M, 3243 E MURDOCK SUITE 300,67208
685-8231
45 M 2604 71 FP
HARTWELL, RICK L, 550 N HILLSIDE, 67214
688-2222
55 M 1902 82 FP
HARVEY, ROSEMARY B, 635 N MAIN,67203
268-8025
24 F 1902 49 AOM
HASAN, SANJIDA, 5136 ZIMMERLEY,67218
-
41 F P

HASSAN, RIZWAN U, 1515 S CLIFTON STE 360,67218
686-2831
47 M 70305 70 N
HATTRUP, RICHARD J, 610 N TYLER,67212
722-8837
31 M 3006 57 FP
HAWLEY, RAYMOND G, 929 N ST FRANCIS,67214
268-5559
39 M 1902 65 PATH
HAYES, WILLIAM L, 3243 E MURDOCK,67208
684-0251
28 M 1902 53 CD
HAYNES, DEBORAH G, 2020 N WOODLAWN STE 550,67208
683-4334
54 F 1902 79 FP
HAYS, THOMAS H, 7111 E 21ST,67206
684-2851
49 M 1902 75 FP
HEADRICK, DANIEL E, 2022 S RIDGEWOOD,67218
-
56 M 1902 83 ANES
HELLMAN, DAVID W, 8300 UNIVERSITY,67209
-
59 M 1902 87
HENNING, CHARLES E, 320 N HILLSIDE,67214
682-3221
37 M 1902 63 ORS
HERED, JOHN, 1515 S CLIFTON #320,67218
686-7222
41 M 2802 67 N
HERSHBERGER, RAY E, UKSM WICHITA,67214
261-2650
53 M 3005 78 IM
HERSHBERGER, GROVER, D.O., 1245 N WEST ST,67203
945-6910
47 M 2878 79 GP
HERSHORN, SIMON E, 3333 E CENTRAL,67208
685-1291
22 M 1902 46 R
HETT, EDWARD J, 2302 N COOLIDGE,67204
832-9024
55 M 1902 81 FP
HIEBERT, ABRAHAM E, 1530 W 13,67203
-
94 M 2802 25 OO
HINSHAW, ALFRED H, 1655 GEORGETOWN, 67218
-
07 M 1902 33 OO
HINSHAW, CHARLES T, 256 N BLECKLEY DR,67208
-
99 M 4705 26 OO
HINSHAW JR, CHARLES T, 1133 E SECOND,67214
684-7784
32 M 1902 58 PATH
HIRATZKA, TOMIHARU, 6 ST CLOUD PLACE,67230
-
13 M 511 43 OO
HIZON, RAMON R, ST FRANCIS HOSP,67214
268-5906
38 M 74801 62 DR
HODSON, HERVEY R, 8809 E HARRY APT 909,67207
-
03 M 1606 31 OO
HOFFMAN, JAMES E, UKSM WICHITA,67214
261-2650
38 M 1902 64 IM
HOLDEN JR, RAYMOND F, 262 SOUTH BROOKSIDE,67218
-
10 M 2802 33 OO
HOLLAND JR, DAVID L, 2804 E FIRST,67214
-
57 M 1902 84
HOLMES, JED, 7111 E 21ST,67206
684-2851
53 M 3005 78 FP
HON, DAVID E, 803 N SHERIDAN SUITE 1901,57203
-
60 M 1902 86
HORBELT, DOUGLAS V, WESLEY MEDICAL ARTS BLDG,67208
681-0251
47 M 4802 72 OBG
HOUSHOLDER, DANIEL FAIR, 7705 KILLARNEY CT,67206
268-5910
43 M 1902 70 NM
HOUSHOLDER, MARTHA S, 835 NORTH HILLSIDE,67214
685-4395
46 F 1902 72 D
HOWARD, DONALD O, 82 VIA VERDE,67230
-
11 M 1902 38 OO
HUEBERT, DEAN A, 5025 E KELLOGG,67218
682-1534
22 M 1902 46 FP
HULL, KENNETH L, 3429 E DOUGLAS,67218
688-5586
38 M 2301 69 P
HULTGREN, MYRON K, 450 N ARMOUR,67206
689-5775
41 M 1902 68 FP
HUME, JOSEPH W, 5111 E 21ST,67208
685-2223
38 M 1902 69 OBG
HUMMER, LLOYD M, 3311 E MURDOCK,67208
689-9323
32 M 3901 57 IM
HUND, LARRY R, 3333 E CENTRAL SUITE 408,67208
682-0411
52 M 1902 78 PD
HUSTEAD, ROBERT F, 427 N HILLSIDE,67214
683-7200
28 M 801 54 ANES
HUTCHINSON, STEVEN A, 4128 E ENGLISH,67218
-
59 M 1902 84
HUTSEY, PAUL J, 3430 EDGEMONT,67208
-
49 M 1902 85
HYNES, HENRY E, 818 N EMPORIA SUITE 403,67214
262-4467
35 M 53902 58 HEM
IBARRA, J LUIS, 1035 N EMPORIA,67214
262-1853
20 M 64901 46 P
IDBEIS, BADR, 1100 N ST FRANCIS STE 240,67214
262-7662
47 M 87501 72 TS
ISAACS, JUANITA J, 3101 E 9TH,67208
262-7662
43 F 2101 P
JACKSON, CHARLES R, 1035 N EMPORIA,67214
263-0812
27 M 1606 53 GS
JAMES, DONALD L, 1301 N WEST,67203
945-5245
42 M 3901 71 OTO
JAMES, VERNON L, 3333 E CENTRAL SUITE 816,67208
685-5326
29 M 3601 55 PD
JAWADI, JAMEELA HUSAIN, 6713 E 32ND,67226
832-1185
50 F 49521 73 PD
JAZAYERLI, NABIL, 1600 FOLIAGE,67206
688-0321
44 M 87501 70 CD
JEHAN, SAYED S, 635 N MAIN,67203
268-8036
33 M 70403 59 P
JENNEY, CHARLES B, 818 N EMPORIA SUITE 200,67214
263-0296
34 M 2834 61 GS
JENSEN, DARAN L, 3333 E CENTRAL SUITE 301,67208
685-7234
52 M 3005 79 OBG
JESTER, SHELBY L, 818 N EMPORIA STE 307,67214
268-6189
43 F 4102 74 ANES
JOHNSON, CAROLYN K, 550 N HILLSIDE, 67214
688-2360
48 F 1902 80 PD
JOHNSON, CAROL ANN, 3243 E MURDOCK SUITE 303,67208
688-3070
49 F 1902 77 FP
JOHNSON, GEORGE K, UKSM WICHITA,67214
261-2622
40 M 1205 67 IM
JOHNSON, MARGARET J, 3311 E MURDOCK,67208
689-9344
54 F 4804 80 D
JOHNSON, THOMAS E, 3333 E CENTRAL,67208
685-1291
41 M 1643 67 R
JONES, RODNEY L, 818 N EMPORIA #307, 67214
268-6189
56 M 1803 82 ANES
JOSEPH, JAPHET G, 1111 N ST FRANCIS,67214
265-2613
49 M 49531 74 CD
JOST, GARY D, 212 N HILLSIDE,67214
685-5211
51 M 1902 77 GS
JUDILLA JR, FRANCISCO, 2322 EAST CENTRAL,67214
263-6186
44 M 74801 71 ANES
KADISON, HERBERT I, ST FRANCIS HOSP,67214
268-5916
44 M 1611 69 R
KARDATZKE, E STANLEY, PO BOX 18008,67218
267-1041
39 M 1720 64 FP

KAROATZKE, JON K, 8200 W CENTRAL STE 1,67212
722-5001
36 M 1720 62 FP
KASHA, ROBERT L, 1000 S WOODLAWN APT 301,67218
682-1534
11 M 2834 38 GS
KASSEBAUM, KENNETH G, 3420 E DOUGLAS,67208
685-6381
34 M 1606 60 CHP
KAUFMAN, EUGENE E, 3243 E MURDOCK,67208
685-1491
30 M 1902 56 ORS
KEENE, GEORGE H, 5025 E KELLOGG,67218
682-1534
20 M 1902 49 GS
KELLER, JAMES P, 1431 S BLUFFVIEW STE 209,67218
685-1284
48 M 1902 74 IM
KELLY, ROBERT W, 550 N LORRAINE,67214
683-9139
46 M 4802 72 OBG
KENDALL, TOM E, 825 N HILLSIDE,67214
688-7500
37 M 3901 62 PS
KENDRICK, J GILLERAN, WESLEY MEDICAL CENTER,67214
688-2088
20 M 1902 46 ADM
KENNEDY, GERALD T, 2916 E CENTRAL,67214
684-5243
35 M 1902 61 GE
KEYES, MICHAEL J, 3101 E 9TH,67208
684-0201
44 M 2101 70 P
KHICHA, GYANCHAND J, 818 N EMPORIA SUITE 200,67214
263-0296
37 M 49530 61 TS
KHDURY, GEORGE H, 3333 E CENTRAL SUITE 416,67208
681-2021
32 M 33002 55 PD
KIM, PAIK N, 3243 E MURDOCK SUITE 404,67208
262-4467
33 M 58302 58 HEM
KIMBLE, JAMES A, 3311 E MURDOCK,67208
689-9316
45 M 702 71 OPH
KIRK JR, E DAVID, 1431 S BLUFFVIEW DRIVE,67218
685-1351
34 M 1902 62 IM
KISER, JOHN L, 3243 E MURDOCK,67208
685-6222
37 M 2802 62 GS
KISER, WILLARD J, 1446 WILLOW RD,67208
-
05 M 4705 30 OD
KITCHEN, ROBERT R, 3420 E DOUGLAS,67208
685-2355
26 M 1902 52 CHP
KLINGMAN, DIANE D, 2020 N WOODLAWN #550,67208
683-4334
53 F 1902 79 FP
KNAPP, LESLIE E, 302 S CRESTWAY,67218
-
96 M 1902 25 OD
KNAPP, M ROBERT, 810 N LORRAINE,67214
685-2207
23 M 3519 47 ANES
KNEIDEL, THOMAS W, 732 N TOPEKA,67214
267-1924
40 M 4101 66 ORS
KNIGHT, LAURA C, ST FRANCIS REG MED CTR,67214
269-5922
42 F 502 68 OR
KNIGHT, PHILIP J, 818 N EMPORIA SUITE 200,67214
263-0296
42 M 0502 68 PDS
KOURI, SAMMY H, 3243 E MURDOCK,67208
682-2911
33 M 3901 57 GS
KRAUSE, ROLAND L, 855 N HILLSIDE,67214
25 M 1902 53 OD
KREADY, JOHN L, 3243 E MURDOCK SUITE 300,67208
685-8231
48 M 1902 79 FP
KRUPKA, JOHN J, 818 N EMPORIA #201,67214
263-0348
47 M 1642 73 NS
KUBIN, SUSAN D, 411 S CHAUTAUQUA, 67211
--
59 F 1902 85
KUBINA, GLENN RICHARD, MID-KANSAS ENT ASSOC,67211
684-2838
47 M 3840 72 DTO
KURTH, C JOSEPH, 200 S ROCK RD SUITE H,67207
-
10 M 3006 35 DD
KUTILEK, FRANK J, 7200 W 13TH ST SUITE 3,67212
722-1200
30 M 1902 57 FP
LAI, JENG Y, 959 N EMPORIA STE 205,67214
265-4701
41 M 38502 67 TS
LANCE JR, JOHN F, 36 VIA ROMA,67230
-
20 M 1902 45 OD
LATIMER, KATHERINE, 3243 E MURDOCK SUITE 401,67208
686-7327
49 F 1205 75 ANES
LAUDERT, SUSAN E, 2330 N OLIVER #724, 67220
--
51 F 1902 87
LAUVER, MARY ANN, 818 N EMPORIA SUITE 303,67214
265-3774
40 F 1902 74 PD
LAWN, CLAUDIA A, PD BOX 47669,67201
264-2401
50 F 1902 75 R
LAWN, RAYMOND A, 715 N MISSION RD,67206
683-8991
09 M 2604 35 AM
LEAR, REX V, 400 W CENTRAL SUITE 1514,67203
-
60 M 1902 86
LEE, R REX, 6155 E HARRY,67218
685-2306
29 M 3901 55 FP
LEE JR, EDWARD S, 2002 E 17TH ST,67214
-
09 M 4707 37 FP
LEISY, JERALD W, 3310 E DOUGLAS SUITE 101,67208
681-2937
42 M 1902 68 P
LEITNER, YORAM B, 3311 E MURDOCK,67208
689-9227
53 M 3519 77 OTO
LEVINE, WILLIAM R, UKSM-WICHITA,67214
261-2647
42 M 1902 67 P
LIES, RICHARD B, 3311 E MURDOCK,67208
689-9131
42 M 1902 68 RHU
LIN, JOE J, 929 N ST FRANCIS,67214
268-5420
42 M 24404 69 PATH
LINDSTROM, LORI A, 7007 E ZIMMERLY,67207
-
56 F 1902 85
LINHAROT, RONALD D, 3243 E MURDOCK,67208
683-2655
36 M 2803 64 OBG
LITTELL, JAMES A, 1520 S CLIFTON,67218
689-5775
44 M 1902 71 EM
LITTLE, L GILBERT, 122 S WESTFIELD AVE,67209
-
99 M 401 27 P
LOCKHART, JOSEPH G, 5900 E CENTRAL,67208
684-7239
17 M 4113 43 PD
LOEFFLER, JAMES A, 400 N WOODLAWN,67208
685-5375
36 M 3841 63 A
LOEWEN, HENRY H, 2142 W 17TH,67203
-
03 M 1902 35 OD
LOEWEN, WILLIAM C, 8200 W CENTRAL STE 1,67212
722-5001
41 M 1902 71 FP
LOGAN, GEOFFREY G, 212 N HILLSIDE,67214
682-4572
31 M 14303 56 OBG
LOSEE, JOHN M, 3243 E MURDOCK STE 401,67208
686-7327
51 M 4301 77 ANES
LOVE, ROBERT H, 348 S GREEN,67211
-
50 M 1902 86
LOVETT, PAUL A, 110 PATTON,67208
-
09 M 1902 45 ORS
LOW, HAROLD L, 1148 S HILLSIDE,67211
684-2858
18 M 1902 44 FP
LUCAS, GEORGE L, 3311 E MURDOCK,67208
689-9495
34 M 1001 61 ORS
LUEKEN, LUEKE B, 3311 E MURDOCK,67208
689-9234
23 M 40723 52 OBG
LUELLEN, THOMAS J, 3311 E MURDOCK,67208
689-9244
17 M 1902 41 IM

LUNBERRY-HILL, JULIA, 11621 ROLLING HILLS,67212
-
55 F 1902 85
LUZZATI, ENZO F, ST FRANCIS HOSPITAL,67214
268-5915
25 M 56119 50 R
LYGRISSE, DANIEL V, 1910 CHARLOTTE,67208
688-2222
50 M 64914 78 FP
LYLE, LINDA S, 1542 FAIRVIEW, 67203
--
53 F 1902 87
LYNCH, MARY A, 320 N HILLSIDE,67214
682-3221
48 F 1002 77 SM
MADDEN, CATHERINE E, 1111 N ROOSEVELT, 67208
--
59 F 1902 87
MAGER, ELAINE M, 448 N FOUNTAIN,67208
687-4431
56 F 1902 83 FP
MAGISON JR, WARD N, 3600 E HARRY,67218
689-5668
37 M 3601 62 PATH
MAGIDSON, ELLIOTT ARTHUR, WESLEY MED CENTER,67214
688-2824
43 M 1611 68 PATH
MAGSALIN, ROMULO O, 1520 S CLIFTON,67218
689-5775
40 M 74808 60 GP
MAILMAN, GERSHOM, ST JOSEPH MED CENTER,67218
685-1111
26 M 3519 49 ANES
MANOELBAUM, MARK A, 3311 E MURDOCK,67208
689-9137
53 M 3901 79 N
MANNING, ROBERT T, UKSM WICHITA,67214
688-2212
27 M 1902 54 IM
MANSOUR, BADIE S, 3243 E MURDOCK SUITE 401,67208
686-7327
45 M 33002 69 ANES
MARSH, HENRY O, 818 N EMPORIA SUITE 306,67214
262-7598
18 M 1611 43 ORS
MARTIN JR, GLEN E, 2322 E CENTRAL,67214
263-6186
20 M 1902 49 ANES
MARYMONT JR, JESSE H, WESLEY MED CENTER,67214
688-2848
28 M 3515 54 PATH
MASSOTH, SUE V, 744 S ESTELLE,67211
687-5470
52 F 1902 86
MASTIO JR, GEORGE J, 3243 E MURDOCK,67208
684-5235
25 M 1902 52 GS
MATASSARIN, BENJAMIN M, 2916 E CENTRAL,67214
684-5243
20 M 1902 45 IM
MATASSARIN, FREDERICK W, 734 N EMPORIA,67214
265-2382
15 M 1902 37 U
MAWDSLEY, MICHAEL W, UKSM-WICHITA, 67214
687-3618
49 M 1902 74 PD
MCBATH, TIM L, 6909 STONEGATE, 67206
--
58 M 1902 87
MCBOYLE, MARILEE, 818 N EMPORIA,67214
263-0296
52 F 1902 77 GS
MCCLANAHAN, WARD A, 5105 E 21ST,67208
684-8211
22 M 3005 48 ORS
MCCLELLAN, ERNEST L, 3243 E MURDOCK SUITE 401,67208
686-7327
38 M 4802 70 ANES
MCCOY, C PATRICK, 3243 E MURDOCK SUITE 401,67208
686-7327
53 M 1902 79 ANES
MCCOY, CHARLES P, 3333 E CENTRAL,67208
685-7234
17 M 3006 42 OBG
MCCULLOUGH, JAMES P, WESLEY MED CENTER LAB,67214
688-2807
54 M 1902 79 PATH
MCDONOUGH, W DAVID, 3311 E MURDOCK,67208
689-9239
48 M 3305 76 U
MCGUIRE, WILLIAM F, 3333 E CENTRAL,67208
683-5655
17 M 4101 43 PD
MCMULLEN, BRUCE R, 1122 S CLIFTON,67218
682-5012
53 M 4002 79 IM
MCNICKLE, GEORGE A, 222 S RIDGE RD,67209
945-0142
49 M

MCQUEEN, DAVID ARNOLD, 818 N EMPORIA,67214
262-7598
47 M 64914 75 ORS
MEANS, MILA LEE, 3447 E MURDOCK,67208
-
56 F 1902 78 FP
MEEK JR, JOSEPH C, UKSM-WICHITA, 67214
261-2635
31 M 1902 57 IM
MEEKER II, BRUCE P, 345 N HILLSIDE,67214
686-3384
30 M 1902 58 OBG
MELEAN, JAIME, 1152 SOUTH CLIFTON,67218
688-0321
40 M 17602 65 CO
MELHORN, J MARK, 656 S LORRAINE,67211
268-5989
53 M 1902 80 ORS
MELHORN, KATHERINE J, 656 S LORRAINE,67211
268-8302
55 F 1902 81 PD
MENAKER, JEROME S, 2703 E CENTRAL,67214
685-1277
16 M 1002 41 OBG
MENDIDNES, L MARLENE, 2501 E CENTRAL,67214
685-4395
45 F 1611 70 D
MENDIDNES, RUPERTO O, 2501 E CENTRAL,67214
687-5773
44 M 1611 71 IM
MENEHAN, H JAMES, 3311 E MURDOCK,67208
689-9404
26 M 1902 53 PD
MENHUSEN, MONTY J, O.D., 3243 E MURDOCK SUITE 401,67208
686-7327
48 M 1676 79 ANES
MENKING, F W MANFRED, 3244 E DOUGLAS,67208
689-9336
34 M 40715 61 PD
MENKING, SUSAN MARGARET, UKSM WICHITA,67214
261-2631
41 F 3840 67 PD
MERCADER, MARIO S, 818 N EMPORIA SUITE 307,67214
258-6189
43 M 74801 64 ANES
MEREDITH, W TOM, 1035 N EMPORIA,67214
263-7285
35 M 4812 61 IM
MERRIFIELD, TERRY S, 3243 E MURDOCK STE 300,67208
685-8231
47 F 1002 75 FP
MERSHON, JAMES C, 3311 E MURDOCK,67208
263-5889
37 M 1803 63 CO
MESSAMORE, DEBRA L, 2308 S BELMONT,67218
-
58 F 1902 84
MEYER, WARREN E, 1515 S CLIFTON SUITE 420,67218
684-5237
27 M 1606 51 GS
MICHELBACH, ALBERT P, 2916 E CENTRAL,67214
684-5243
35 M 2101 61 IM
MILFELD, DOUGLAS J, 818 N EMPORIA SUITE 200,67214
263-0296
45 M 4804 72 TS
MILLER, DAVID PATERSON, 7111 E 21ST N,67205
685-2387
50 M 2803 77 FP
MILLER, DON E, 4145 E KELLOGG,67218
682-6551
20 M 2802 44 GS
MILLER, ROGER M, AMERICAN RED CROSS,67202
265-6601
37 M 4102 63 BLB
MILLS, CHARLES O, 1140 S WATER,67213
-
89 M 2002 14 OD
MILLS, KIRK C, 903 N EDGEMOOR,67208
-
57 M 1902 86
MILLS, PHILIP R, 16 WILLOWBROOK RD,67207
683-6613
49 M 512 76 PM
MINNS, GARDLO D, UKSM-WICHITA DEPT OF MED,67214
261-2650
51 M 1902 76 IM
MIRZA, MEDO, 3333 E CENTRAL,67208
686-6683
38 M 40733 64 PDS
MONTGOMERYSHORT, RUTH G, 1019 W 50TH NORTH,67204
-
10 F 1902 37 OD
MOORE, DENNIS F, 1035 N EMPORIA,67214
265-3226
36 M 2101 62 HEM
MOORE, THOMAS A, 7439 TANGLEWOOD,67206
-
52 M 1902 88

MORGAN, JAMES I, PO BOX 17007,67217
522-2266
29 M 1606 53 FP
MORGAN, RANDALL J, 212 N HILLSIDE,67214
682-4572
52 M 1902 77 OBG
MORGAN III, LOUIS S, 8030 E KELLOGG,67207
683-3811
22 M 3901 48 FP
MORRISON, RICHARD L, 1148 S HILLSIDE,67211
684-3391
42 M 1902 67 FP
MORROW, THOMAS F, 3310 E DOUGALS,67208
685-1443
21 M 5606 46 P
MOSELEY, JACK E, 1120 S CLIFTON,67218
582-4982
25 M 3901 53 FP
MOSIER, STANLEY JAY, 3243 E MURDOCK,67208
685-8231
42 M 1902 68 FP
MUELLER, VERNETTE A, 1431 S BLUFFVIEW,67218
684-3981
17 M 2802 41 OBG
MUETH, JOAN D, 7111 E 21ST,67206
684-2851
53 F 2803 79 FP
MULLINIX, JANICE M, 3333 E CENTRAL SUITE 533,67208
687-5443
47 F 3006 73 N
MURPHY, BARRY L, 3243 EAST MURDOCK #500,67208
684-0251
45 M 1902 71 IM
MURPHY, DUANE A, 3243 E MURDOCK,67208
685-1491
32 M 1902 65 ORS
MURPHY, PATRICK L, MED CHECK - TOWN EAST,67207
587-4020
55 M 3901 81 FP
MURPHY, PAUL M, 3600 E HARRY,67218
689-5050
28 M 3006 51 R
MURPHY, WILLIAM R C, 818 N EMPORIA SUITE 200,67214
263-0296
43 M 1611 68 TS
MURRAY, KENT B, VETERANS MEDICAL CENTER,67218
261-2650
47 M 3901 73 IM
NEASE JR, DONALD E, 2330 N OLIVER #523, 67220
--
61 M 1902 87
NELLIS, STEPHANIE F, 3311 E MURDOCK,67208
689-9270
53 F 1902 79 IM
NELSON, GERALD O, 825 N HILLSIDE,67214
688-7500
34 M 1902 60 PS
NELSON, RUSSELL ALAN, C/O WESLEY/PERINATAL,67214
688-2360
18 M 1902 45 PD
NELSON JR, GUST H, 3600 E HARRY,67218
689-5050
23 M 1902 46 OR
NESMITH, LESLIE W, 3333 E CENTRAL,67208
683-5611
40 M 1902 66 OPH
NETHERTON, DAVID M, 7111 E 21ST,67206
684-2851
55 M 2803 81 FP
NEWBY, JAMES P, 818 N EMPORIA SUITE 200,67214
263-0296
34 M 1902 59 TS
NEWLIN, PHILIP L, 351 MARION COURT #1,67216
-
61 M 1902 87
NEWSOM, F CARTER, 3310 E DOUGLAS,67208
685-1443
18 M 1201 43 P
NIELSEN, MARY L, WESLEY MED CTR LAB DEPT,67214
688-2468
47 F 1902 77 PATH
NIXON, WILLIAM A, 3333 E CENTRAL SUITE 525,67208
683-6622
16 M 1902 44 GS
NORMAN, BENJAMIN R, 1402 E CATALINA,67216
-
56 M 1902 85
NORRIS, ROBERT P, 3311 E MURDOCK,67208
689-9232
17 M 1902 43 IM
NORTH, DORIS G, 1148 S HILLSIDE,67211
684-5257
16 F 1902 47 FP
NORTON, ROBERT K, 3311 E MURDOCK,67208
689-9235
32 M 1001 57 PD
NOWLIN, NANCY S, 1001 N MINNEAPOLIS,67214
268-8378
47 F 1902 74 IM
NUILA, RICHARD F, 3311 E MURDOCK,67208
689-9234
50 M 34104 76 OBG
O'DONNELL JR, LEONARD A, 8033 E DOUGLAS,67207
684-2835
27 M 1902 55 IM
OCHSNER, BRUCE B, 1035 N EMPORIA SUITE 235,67214
263-6273
39 M 1902 65 OPH
OPENHEIMER, BURTRAM J, 3311 E MURDOCK,67208
689-9137
48 M 2105 73 N
ORTH-BAALMAN, DIANE M, UKSM-WICHITA,67214
-
56 F 1902
OSBORN, J CLARK, 1518 HASKELL,67213
-
57 M 3901 83 FP
OSBORNE, CONRAD C, 855 N HILLSIDE,67214
685-1381
38 M 1902 67 FP
OSIO, ANTONIO L, 1520 S CLIFTON,67218
689-5775
41 M 26404 65 EM
OSOBA, WILLIAM G, 2525 W 13TH,67203
943-9391
25 M 2802 51 FP
OSTER, JOYCE A, 3311 E MURDOCK,67208
689-9422
54 F 1902 79 OR
OUANO JR, BIBIANO B, 1515 S CLIFTON SUITE 380,67218
684-5094
40 M 74801 63 U
OWEN, LARUE W, 236 N BELMONT,67208
-
19 M 1902 50 OO
OWEN, PERE A, 1128 S CLIFTON,67218
684-7251
37 M 1902 64 ANES
PAGE, RUTH, 1051 N STRATFORD,67206
-
13 F 1902 43 OO
PALMER, DAVID L, PO BOX 9406,67277
945-5177
37 M 1902 63 A
PARK, ROGER WALTER, 3311 E MURDOCK,67208
689-9217
43 M 1902 69 PD
PARKER, HAROLD L, 3311 E MURDOCK,67206
684-1599
32 M 1902 67 FP
PARMAN, CRAIG R, 905 N EMPORIA,67214
-
56 M 1902 84
PARSONS, JULIE A, 2323 N WOODLAWN #225,67220
-
61 F 1902 87
PASSMAN, STEVEN M, 835 N HILLSIDE,67214
685-4395
47 M 2803 73 O
PATTON, J MICHAEL, 1431 S BLUFFVIEW STE 210,67218
686-2111
51 M 3005 78 FP
PAXTON, EDWARD SCOTT, 3600 E HARRY,67218
689-5675
51 M 2802 77 PATH
PAY, NORMAN T, ST FRANCIS HOSP,67214
268-5914
45 M 74802 68 NR
PEERY, WILLIAM H, UKSM WICHITA,67214
261-2650
46 M 4802 73 IM
PEIL, MICHAEL L, 1035 N EMPORIA #290,67214
269-4026
54 M 1902 80 PM
PELLETIER JR, LAWRENCE L, UKSM WICHITA,67214
261-2650
42 M 3501 68 IM
PENN, CHRISTOPHER C, 211 N BATTIN, 67208
--
62 M 1902 88
PENCE, CHARLES O, 3311 E MURDOCK,67208
689-9468
42 M 1902 68 ORS
PENNINGTON, KATHERINE, 2113 SO BLUFF CT,67218
685-5271
16 F 1902 43 PD
PETERIE, JERRY P, 818 N EMPORIA SUITE 305,67214
264-3505
48 M 1902 75 IM
PETERS, THOMAS J, 3244 E DOUGLAS,67208
689-9190
47 M 2803 77 IM

PHAN, OUNG MY, 959 N EMPORIA S 28,67214
267-5580
48 F 94101 75 FP
PHIPPS, JACK G, 315 N HILLSIDE,67214
686-3391
21 M 1902 53 FP
PIBURN, MARVIN F, 125 N ZELTA,67206
267-4201
22 M 1803 48 GS
PICKENS, ANDREW T, WICHITA PSY PO BOX 8037,67208
684-0201
43 M 2834 69 P
PINSKER, JACOB A, 1035 N EMPORIA,67214
-
06 M 1902 3S IM
POLINER, LAWRENCE R, 818 N EMPORIA SUITE 407,67214
264-8604
43 M 3S20 69 CO
POLING, TERRY L, 61S5 E HARRY,67218
68S-2306
36 M 1902 62 FP
POLLACK, SIMON, 7523 PLAZA LANE,67206
-
M 36 OO
POLLANO, STEPHEN M, O.O., 1035 N EMPORIA SUITE 18S,67214
255-S291
39 M 2878 68 PM
POLLOCK, ANTHONY G A, 825 N EMPORIA,67214
264-2806
45 M 830S 71 ORS
POOLE, BERNARD T, 82S N EMPROIA,67214
264-2806
37 M 53902 62 ORS
PORTER, GARRY L, 3243 E MUROOCK STE 400,67208
686-7351
35 M 1606 61 P
PORTER, TAYLOR L, 718 S HYDRAULIC, 67211
--
60 M 1902 87
POWERS, K DEAN, 2703 E CENTRAL,67214
685-1277
23 M 1902 47 OBG
PULLMAN, NORMAN K, 3007 E CENTRAL,67214
686-7369
21 M 3006 45 PS
PULLUM, RICHARD W, O.O., 2622 W CENTRAL,67203
945-9161
27 M 1875 57 R
PURINTON, LEW W, 1431 S BLUFFVIEW OR,67218
585-1301
23 M 1902 48 IM
PUTNAM, LYLE B, 4700 W 13TH UNIT 1-1,67212
-
11 M 1902 36 OO
RAGHAVAN, PARULA P, 2404 GREENLEAF CT,67226
263-6131
47 F 49S01 70 IM
RAGHAVAN, PRAKASH V, 1100 N ST FRANCIS STE 240,67214
262-7662
46 M 49S01 69 CO
RAMOS, MICHAEL, 905 N EMPORIA,67214
265-2876
55 M 702 81 FP
RAMZY, MERIT S, 1784 N PINECREST,67208
-
56 F 1902 86
RANDALL, GEORGE R, MID-KANSAS ENT ASSOC,67211
684-2838
43 M 2802 69 OTO
RANDLES, MICHAEL J, 9S9 N EMPORIA,67214
265-2924
48 M 1902 73 IM
RAUSA JR, FRANCISCO C, 1148 SOUTH HILLSIDE,67211
683-4658
42 M 74808 66 IM
RAWCLIFFE JR, ROBERT A, 732 N TOPEKA,67214
267-1924
29 M 3501 55 ORS
RAZEK, HANA A, WESLEY MED CTR PATH DEPT,67214
688-2828
47 F 33004 71 PATH
RAZEK, ZACK A, 818 N EMPORIA SUITE 200,67214
263-0296
46 M 60501 70 COTS
READER, G WHITNEY, 3311 E MUROOCK,67208
263-S889
48 M 2101 70 CO
REALS, WILLIAM J, UKSM WICHITA,67214
261-2600
20 M 3006 45 PATH
REAZIN, WALTER L, 1430 HOMESTEAD,67208
685-1381
30 M 1902 58 FP
REDDI, RAGHUNATH P, ST JOSEPH MEDICAL CTR,67218
689-5043
36 M 49521 64 RT
REED, A J, 1S20 S CLIFTON,67218
685-5775
40 M 3901 6S EM
REED, D CRAMER, WESLEY MED CTR HLTH STRAT,67214
688-2080
1S M 2802 41 AOM
REED, DAVID O, 3333 E CENTRAL,67208
685-1291
43 M 1902 69 OR
REED, WILLIAM RANDALL, 550 N HILLSIDE,67214
688-2360
51 M 1611 77 NEO
REISMAN, MICHAEL ALAN, 3243 E MUROOCK SUITE 600,67208
683-5688
SO M 4804 7S OPH
REISWIG, JEFFREY SCOTT, 1733 N SHERIDAN,67203
-
60 M 1902 86
RELIHAN, DONALD A, 655 N WOODLAWN,67208
684-S1S8
27 M 1902 54 OPH
REMPEL, JOHN H, 1515 S CLIFTON SUITE 240,67218
685-1812
38 M 3901 62 PS
REUSSER, LAYNE M, 2330 N OLIVER #317,67220
-
60 M 1902 86
REZAEI, SHIRLEY J, 6519 WENDELL, 67219
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58 F 1902 87
RHOADS, JAMES P, 3311 E MUROOCK,67208
689-9106
34 M 3S20 60 IM
RHODEN, CURTIS H, 3243 E MUROOCK,67208
684-0252
33 M 1606 59 IM
RHODES, IVAN E, 3635 ELMWOOD,67218
-
25 M 3901 49 R
RHODES, LOWELL M, 31S N HILLSIDE,67214
685-1461
2S M 1902 S3 FP
RICHARDSON, STEWART F, 3420 E DOUGLAS,67208
685-2321
28 M 300S 54 P
RIEDERER, ROBERT E, 1131 S CLIFTON,67218
685-43S4
16 M 1902 42 FP
RIEGER, ERNEST H, 3243 E MUROOCK,67208
682-4S91
29 M 1902 56 GS
RIEPE, ROGER E, WESLEY MED CENTER,67214
688-282S
46 M 1803 74 PATH
RIGGS, PAUL A, 3S21 E SKINNER,67218
-
54 M 80 GS
RIORDAN, HUGH O, 3100 N HILLSIDE,67219
682-9241
32 M S605 S7 P
ROACH, NEIL E, UKSM WICHITA,67214
268-8388
38 M 1902 67 CP
ROAN, YEAI, PERINATAL DIVISION,67214
688-2384
41 M 38S01 67 PO
ROBERTS, DANIEL K, 3333 E CENTRAL SUITE 301,67208
688-3185
36 M 3005 61 OBG
ROBERTS, ROGER W, O.O., PO BOX 47668,67201
264-8604
49 M 2879 7S CO
ROBERTSON, JOSEPH K, 818 N EMPORIA SUITE 200,67214
263-0296
41 M 3901 66 GS
ROBINSON, G DONALD, 3333 E CENTRAL,67208
686-6659
28 M 1902 54 PO
ROBINSON, JOHN E, 2708 E CENTRAL,67214
686-7351
32 M 6201 50 P
ROBINSON, ROBERT H, 3311 E MUROOCK,67208
689-9445
20 M 1902 53 ANES
ROBL, DAVID A, 8200 W CENTRAL STE 1,67212
722-6892
48 M 1902 74 FP
ROCK, RANDALL W, 3243 E JUROOCK STE 313,67208
-
57 M 1901 83 RP
RODRIGUEZ-RAMOS, ERNEST R, 1111 N ST FRANCIS,67214
265-2613
42 M 27501 67 COTS
RODRIGUEZTOCKER, LILIA, 1111 N ST FRANCIS,67214
265-2613
21 F 27S01 49 IM

ROMALIS, BRIAN E. 3429 E DOUGLAS,67218
682-5069
39 M 6201 63 P
ROOS, MAUREEN, 905 N EMPROIA,67214
265-2876
53 F 1902 75 FP
ROSE, SHELBY O. 3333 E CENTRAL,67208
681-2741
40 M 2012 68 PATH
ROSEN, DAVID, 818 N EMPORIA #303,67214
265-3774
48 M 1902 74 PO
ROSENBERG, THOMAS F. 2627 E CENTRAL,67214
684-0501
41 M 1642 68 A
ROSIN, ROBERT L. 3644 COUNTRY CLUB,67208
-
50 M 1902 85
ROSS, DENNIS LEE, 1035 N EMPORIA SUITE 105,67214
263-7285
47 M 3005 73 NEP
RUSSELL, PHILIP W. 3311 E MURDOCK,67208
689-9351
22 M 1902 44 IM
SABIN JR, GEORGE M. 707 N MAIN,67203
268-0824
12 M 5002 39 AOM
SACK, JOSEPH M, 1704 W 32ND, 67204
--
60 M 1902 87
SAOIO, SULEMAN, 1144 N ST FRANCIS,67214
267-0159
40 M 70401 63 TS
SAEED, MOHAMMAD, 1520 S CLIFTON,67218
689-5775
42 M 70404 66 IM
SANDERS, GLORIA D. RIVERSIDE HOSPITAL,67203
945-9161
50 F 1902 75 PATH
SANTOS, JDAQUIN G. 3243 E MURDOCK STE 500,67208
684-0251
49 M 1902 81 IM
SANTOSCOY, GILBERT S. 3311 E MURDOCK,67208
689-9124
38 M 4812 62 GS
SATHER, R ALAN, 3243 E MURDOCK SUITE 303,67208
688-3070
35 M 2604 68 FP
SCANLAN, TIMOTHY M. ST JOSEPH MED CTR-ATU,67218
689-4850
46 M 2604 71 FP
SCHILTZ, FRANCES, 115 S RUTAN #108,67218
-
93 F 6701 23 OD
SCHLACHTER, ERNEST R. 406 E CENTRAL,67202
265-0705
24 M 1902 52 FP
SCHLICHER, JOHN E. 3311 E MURDOCK,67208
689-9346
40 M 1803 66 O
SCHLUETER, JOHN J. 144 S HILLSIDE,67211
685-9289
31 M 3841 56 R
SCHLYER, ARTHUR M. 940 N TYLER,67212
721-1111
51 M 1902 80 FP
SCHNELLE, JOACHIM, 414S EAST KELLOGG,67218
682-0621
44 M 40933 70 FP
SCHOPF, CLIFTON C. 222 S RIDGE RD,67209
945-0142
29 M 1902 57 FP
SCHWARTZ, V DEAN, 400 N WOODLAWN #4,67208
684-3881
24 M 1902 48 FP
SCOTT, WILLIAM H. 1431 S BLUFFVIEW STE 111,67218
685-1111
41 M 4901 65 CO
SEN SARMA, PRONAB K. 1144 N ST FRANCIS,67214
267-0159
45 M 49518 71 CO
SHAFER, PRESTON J. 3333 E CENTRAL,67208
685-7234
20 M 3005 46 OBG
SHAH, MUKHTAR H. 3243 E MURDOCK STE 400,67208
686-2994
40 M 70404 63 P
SHAPIRO, WILLIAM M. 818 N EMPORIA STE 201,67214
263-0348
45 M 1606 76 NS
SHAW, RICHARD C. 825 N HILLSIDE,67214
688-7500
35 M 1902 61 PS
SHEHI, LORA J. 834 CARTER,67203
-
56 F 1902

SHELLITO, JOHN G. 3311 E MURDOCK,67208
-
18 M 1606 43 OO
SHELLITO, JOHN L, 3311 E MURDOCK, 67208
689-9124
52 M 2407 78 GS
SHERDON, MARY LOU, 3439 S DONN,67217
-
47 F 1902 87
SHIELD, CHARLES, 818 N EMPORIA SUITE 200,67214
263-0296
46 M 2802 72 GS
SHOFFNER, RICHARD W. 3311 E MURDOCK,67208
689-9271
53 M 3901 79 IM
SHRADER, C ERIC, 655 N WOODLAWN,67208
684-5158
47 M 1902 78 DPH
SHRADER, DOYLE A. 3333 E CENTRAL,67208
682-4851
16 M 1902 41 EENT
SHUMARD, CRAIG J. 621 IDA,67211
267-8582
60 M 1902 86
SHURTZ, GLEN L. 3333 E CENTRAL SUITE 214,67208
685-1291
40 M 4802 78 R
SIEGEL, ALBERT R. 3600 E HARRY,67218
689-4797
22 M 1642 47 PM
SIEMENS, CHARLOTTE A. 430 BLAKE,67213
-
60 F 1902 86
SIFFORD, R LAWRENCE, 959 N EMPORIA,67214
265-0561
25 M 1803 52 IM
SIMMS, DAVID ALAN, 3311 E MURDOCK,67208
689-9422
50 M 3401 76 OR
SKIBBA, RICHARD M. 3311 E MURDOCK,67208
689-9477
43 M 5606 70 GE
SKOCH, MICHAEL G. 2310 WHITE OAK DR,67207
-
57 M 1902 84
SLUTSKY, LAWRENCE JOEL, ST FRANCIS HOSPITAL,67214
268-5922
46 M 3501 72 OR
SMITH, ALVIN L. 929 N ST FRANCIS,67214
268-5470
28 M 5606 57 PATH
SMITH, TIMOTHY WM, 1035 N EMPORIA STE 290,67214
269-4026
49 M 1902 74 IM
SMITH JR, WILLARD J, 851 N HILLSIDE,67214
685-1371
32 M 1611 57 U
SNYDER, GREGG M. 902 N HILLSIDE,67214
687-1441
27 M 1803 54 NS
SOLOMON, HERMAN, 835 N HILLSIDE,67214
685-4395
37 M 2701 62 O
SOLTZ, ROBERT A. 3311 E MURDOCK,67208
689-9381
47 M 2803 74 PO
SOMERS, MARVIN M. ST FRANCIS HOSP,67214
268-5909
23 M 1902 48 R
SPANN, RICHARD W. 3243 E MURDOCK,67208
684-0252
40 M 1902 65 PUO
STAMBAUGH, ROY A. 2456 N WOODLAWN,67220
685-5691
34 M 2501 60 EM
STAMPS, PHIL, ST JOSEPH MEDICAL CENTER,67218
689-5668
37 M 3901 63 PATH
STANLEY, KENNETH E. 959 N EMPORIA,67214
267-0256
31 M 1902 56 U
STARK, JAMES R. 3311 E MURDOCK,67208
689-9422
20 M 1902 44 R
STECKLEY, RICHARD ALLEN, PO BOX 47669,67201
265-1308
49 M 2105 74 IM
STEELBERG, ELSIE, 337 N WACO,67202
265-8872
34 F 1606 60 P
STEELE, ROBERT E. HERTZLER CLINIC,67212
721-1111
30 M 2501 59 FP
STEIN, PAUL S. 3243 E MURDOCK,67208
685-2377
40 M 3305 66 NS

STEMBRIDGE, TRAVIS W, 3333 E CENTRAL SUITE 301,67208
685-7234
47 M 4802 76 OBG
STEPHANZ JR, GERALD B, 834 CARTER,67203
265-5554
57 M 1902
STEWART, DANIEL L, 649 N HILLSIDE,67214
-
61 M 1902 87
STRAIN, LORRAINE L, 2621 E DOUGLAS, 67211
--
58 F 1902 87
STREET, DAVID E, 818 N EMPORIA SUITE 200,67214
263-0296
35 M 2101 61 GS
STREIT, JEROME G, 1131 S CLIFTON,67218
685-4354
48 M 1902 77 FP
STRICKLAND, M H VAN, 3100 N HILLSIDE,67219
682-3100
51 A
SUERO, JESUS T, 1148 S HILLSIDE,67211
681-3371
33 M 74802 57 PUD
SULLIVAN, CORNELIUS J P, PO BOX 8503,67208
-
18 M 3509 43 OD
SULLIVAN, LEONARD L, 3311 E MURDOCK,67208
689-9454
35 M 1902 61 PD
SUMMERS, LAURIE K, 1520 N DELL RDSE,67208
-
54 F 1902 86
SVOBODA, LOIS V, 3243 E MURDOCK STE 300,67208
685-8231
39 F 1602 66 FP
SVOBODA, WILLIAM B, 3243 MURDOCK SUITE 601,67208
685-2377
36 M 1602 63 PDN
SWARTZ, MARSHA A, 1840 S LAUREL,67206
-
44 F 1902 86
SWEET, DONNA E, UKSM WICHITA,67214
268-8378
48 F 1902 79 IM
TARVER, STEPHEN D, 3513 N ATHENIAN,67204
-
58 M 1902 85
TATPATI, DANIEL A, 1144 N ST FRANCIS,67214
267-0159
44 M 49535 67 TS
TATPATI, OLGA ADELINA, UKSM WICHITA,67214
268-5992
44 F 49535 67 PD
TAYLOR, RICHARD J, 929 N ST FRANCIS,67214
268-5527
21 M 3006 49 PATH
TAYLOR, WILLIAM K, UKSM-WICHITA, 67214
261-2650
55 M 3901 81 IM
THELEN, J CHRISTINE, 1738 N ROOSEVELT,67208
-
13 F 5104 37 OD
THOMPSON, DANIEL M, PO BOX 4069,67204
838-3381
19 M 1902 50 FP
THOMPSON, WILLIAM E, PO BOX 8253,67208
-
30 M 3005 55 DPH
TIHEN, EDWARD N, 3244 E DOUGLAS,67208
-
24 M 1606 48 OD
TIHEN, HENRY N, 1227 N RIVER BLVD,67203
-
96 M 1601 19 OD
TILLER, GEORGE R, 5101 E KELLOGG,67218
684-5255
41 M 1902 67 AM
TILTON, FRANK M, 3311 E MURDOCK,67208
689-9137
33 M 2002 59 N
TINKER, ROBERT C, 1126 S CLIFTON,67218
682-7578
31 M 2834 57 ORS
TINTEROW, MAURICE M, 3333 E CENTRAL,67208
-
17 M 4802 41 OD
TIPPIN JR, ERNEST E, 959 N EMPORIA,67214
265-5256
24 M 1902 50 OTO
TOCKER, ALFRED M, 1111 N ST FRANICS,67214
265-2613
15 M 4802 40 COTS
TONN, GERHART R, 855 N HILLSIDE,67214
685-1381
16 M 1902 44 FP
TOOHEY, JOHN S, 3311 E MURDOCK,67208
689-9175
50 M 5605 77 ORS
TOSH, FRED E, 1900 E NINTH,67214
268-8391
30 M 4706 54 PH
TRACY, TERRY A, 3333 E CENTRAL,67208
685-7234
35 M 2803 61 OBG
TRAVERS, HENRY, WESLEY MED CTR LAB MED,67214
688-2812
46 M 4114 71 PATH
TRETBAR, HARVEY A, 3243 E MURDOCK #500,67208
684-0251
25 M 1902 52 IM
TREWEEKE, MICHAEL W, 2916 EAST CENTRAL,67214
684-5234
46 M 1902 72 IM
TRIMMER, KENNETH J, 2804 E FIRST,67214
-
58 M 1902 85
TRUDEAU, DAVID L, ALCOHOL TREATMENT UNIT,67218
689-4850
40 M 2604 66 ADT
TRUJILLO, ANTERO A, 1431 S BLUFFVIEW APT 117,67218
685-6466
36 M 73701 61 ANES
UHLIG, PAUL J, 3311 E MURDOCK,67208
689-9191
28 M 1902 57 PD
VAL-MEJIAS, JESUS E, 818 N EMPORIA SUITE 407,67214
264-8604
45 M 23101 69 IM
VAN ES, GERALD L, 1131 S CLIFTON,67218
689-5500
49 M 1803 75 FP
VAN LEEUWEN, GERARD J, UKSM WICHITA,67214
261-2631
29 M 1803 54 NED
VAUGHN, DONNA A, UKSM-WICHITA, 67214
261-2647
45 F 1902 71 P
VIN ZANT, LARRY E, 1515 S CLIFTON SUITE 270,67218
682-6532
10 M 1902 40 GS
VINE, DONALD LEE, 3311 E MURDOCK,67208
689-9240
39 M 511 66 CO
VINZANT, WHITNEY L, 1515 S CLIFTON SUITE 270,67218
686-1991
45 M 1902 71 GS
VORHEES, VICTOR J, PO BOX 18008,67218
681-1152
36 M 1902 68 FP
VOTH, DOUGLAS W, UKSM WICHITA,67214
261-2650
34 M 1902 59 IM
WADE, EDWARD J, 1036 LAWRENCE CT,67206
686-6835
53 M 1902 80 ANES
WADUD, ABDUL, 1543 S HILLSIDE,67211
682-6814
35 M 70409 60 P
WALKER, MARSHALL D, O.D., 1301 N WEST ST,67203
945-5245
41 M 2878 72 OTO
WALLING, ADRIAN E, 1131 S CLIFTON,67218
689-5500
47 M 80302 71 FP
WALLING, ANNE O, UKSM WICHITA,67214
261-2607
47 F 80302 71
WARD, CYNTHIA L, 2330 N OLIVER APT 309,67220
-
58 F 1902 85
WARD, LARRY G, 818 N EMPORIA STE 307,67214
268-6189
54 M ANES
WARREN, LLOYD P, 5205 E 21ST,67208
683-7223
11 M 1902 36 OPH
WARREN, MARVIN L, 1128 S CLIFTON,67218
681-2108
55 M 1902 80 ANES
WARREN, WIRT A, 2226 S MINNESOTA,67211
267-0520
09 M 2802 33 PGER
WARREN JR, JOHN W, 931 N YALE,67208
-
15 M 2501 39 OD
WATTS, GARRETT E, 249 N BATTIN,67208
-
52 M 3901 75 ORS

WEAVER, J ROBERT, 959 N EMPORIA,67214
265-5731
21 M 1902 48 FP
WEAVER, JACK O, 959 N EMPORIA,67214
265-7241
16 M 2802 42 OPH
WEBER JR, HUGO P, 1035 N EMPORIA,67214
263-7285
40 M 702 66 IM
WEBSTER, BOBBY W, 550 N LORRAINE,67214
685-0559
48 M 4802 74 OBG
WEIPPERT, EOWARD J, 8200 W CENTRAL #1,67212
722-6892
44 M 1902 70 FP
WELCH, ANNA L, 905 N EMPORIA,67214
268-5996
48 F 1720 81 FP
WELCH, LAUREN K, 3243 E MUROOCK SUITE 601,67208
685-2377
35 M 1902 61 N
WELCH, MARTIN H, 1431 BLUFFVIEW,67218
685-3030
36 M 5605 61 IM
WELLS, MAX MICHAEL, 550 N HILLSIDE,67214
688-2820
50 M 1902 76 PATH
WELLSHEAR, CHARLES C, WICHITA PSY CENTER,67208
684-0201
30 M 4706 58 P
WENINGER, JOHN H, 1148 S HILLSIOE,67211
682-6523
32 M 3005 62 FP
WEST, WILLIAM T, 3311 E MURDOCK,67208
689-9234
24 M 1902 49 OBG
WHEELER, NICKY RAY, 1515 S CLIFTON SUITE 390,67218
684-0220
48 M 1902 74 PS
WHEELER, PINCKNEY R, 2208 W 13TH,67203
943-2118
18 M 3901 56 FP
WHITAKER, JAMES A, 3243 E MUROOCK,67208
684-0251
44 M 1902 72 IM
WHITE, CHARLES M, 18 VIA VERDE,67230
-
15 M 3005 41 OO
WHITESIOE, WILLIAM H, ST JOSEPH MEDICAL CENTER,67218
-
46 M 53903 73 PD
WILCOX, ROBERT N, 2451 RUTLAND CT,67226
721-2874
27 M 1902 54 R
WILDER, LOWELL W, 655 N WOODLAWN,67208
684-5158
35 M 4109 62 OPH
WILKINSON, LARRY K, 1520 S CLIFTON,67218
685-2371
46 M 1902 74 FP
WILLIAMS, CHARLES L, 3311 E MURDOCK,67208
689-9268
16 M 2834 43 IM
WILLIAMS, RONALD P, 158 N NEVEDA,67212
-
55 M 4816 76
WILLIAMSON, STEPHEN K, VA MEDICAL CENTER,67218
685-2221
54 M 1902 79 IM
WILLNER, CATHERINE, 1542 FAIRVIEW,67203
-
54 F 1902 86
WINCHESTER, EUGENE B, 2601 E CENTRAL,67214
684-0271
18 M 3006 56 FP
WISDOM, JAY K, 15 LYNWOOD,67207
-
12 M 1902 42 OO
WISNER JR, HARRY J, 3244 E DOUGLAS,67208
689-9169
17 M 3005 43 IM
WITTMANN, ALBERT F, 2323 N WOODLAWN,67220
-
10 M 2834 38 OO
WOLFE, FREDERICK, 1035 N EMPORIA #230,67214
686-1152
36 M 3508 66 RHU
WOOD, GARY B, 2501 E CENTRAL,67214
684-2131
21 M 2802 45 IM
WOOO, ROBERT D, 2337 RUTLAND CT,67226
486-2127
26 M 1902 53 FP
WOODHOUSE, CHARLES L, 959 N EMPORIA,67214
265-8821
10 M 1902 34 ENT
WOODRING, CATHY S, 222 S RIDGE RD,67209
945-0142
51 F 3546 77 FP
WORSING JR, ROBERT A, 3244 E DOUGLAS,67208
689-9175
47 M 2604 72 ORS
WRAY, ALEXANDER J, 120 E 21ST ST,67214
838-4912
19 M 1902 49 FP
WRAY JR, REGINALD D, 3333 E CENTRAL SUITE 602,67208
685-4389
40 M 4113 66 ANES
WU, JIN-TZE, 3333 E CENTRAL SUITE 214,67208
688-2920
41 M 38502 67 TR
YEW, CLAIRE S, 3311 E MUROOCK,67208
689-9327
54 F 2507 80 PD
YOCKEY, CHARLES C, 3243 E MURDOCK S 500,67208
684-0251
46 M 1902 72 IM
YOON, CHANG SUP, 3333 E CENTRAL,67208
685-4389
46 M 58303 72 ANES
YOUNG, OOUGLAS L, 3311 E MURDOCK,67208
589-9213
42 M 1902 71 IM
YOUNGBERG, OEAN I, 2916 EAST CENTRAL,67214
684-5243
46 M 1902 72 IM
ZARNOW, HILARY, ST FRANCIS REG MEO CTR,67214
268-5905
45 M 1611 69 R
ZATZKIN, JAY B, 818 N EMPORIA SUITE 403,67214
262-4467
46 M 2002 74 IM
ZEPICK, LYLE F, 3311 E MUROOCK,67208
263-5889
50 M 6001 71 CD
ZIEGLER, JUDY P, 3211 E MURDOCK, 67208
689-9414
54 F 1803 84 PD
ZIMMERMAN, KENNETH O, 934 CRESTLINE,67212
687-3925
29 M 3901 55 OM
ZONGKER, PHILIP E, 3311 E MURDOCK,67208
689-9422
43 M 1902 70 R

WINCHESTER—913
(Shawnee County Society)

HUSTON, FRANCIS W, DRAWER H,66097
-
06 M 1601 34 FP

WINFIELD—316
(Cowley County Society)

CARRO, F AURELIO, PO BOX 544,67156
221-3200
23 M 27501 49 IM
OAEHNKE, SIGURD S, PO BOX 544,67156
221-3200
26 M 3005 60 FP
FOWLER, DENNIS L, PO BOX 544,67156
221-2300
48 M 1902 73 ES
HUTCHINSON, DIRK T, PO BOX 544,67156
221-3200
48 M 3901 74 IM
KAUFMAN, LELAND R, 221 WEST 8TH,67156
221-3350
33 M 1902 61 FP
KAUL, ANANO N, PO BOX 544,67156
221-3200
39 M 49530 61 IM
MAC KILLOP JR, DANIEL, 4 FLEETWOOD DR,67156
-
11 M 2407 38 OO
MILLER, FRANKLIN R, 301 PARK,67156
-
02 M 2401 27 OO
NEMMERS, OAVID J, PO BOX 544,67156
221-3200
34 M 1803 59 IM

SAMUEL, CHANDY C, 1211 E FIFTH,67156
221-6100
35 M 49S27 59 GS
SAMUEL, SHANTHI, 5 FLEETWOOD DR,671S6
221-2300
42 F 49527 67 PATH
SHAH, ASHOK H, PO BOX 544,67156
221-3200
41 M 4954B 66 OBG
SHEPPARD, THOMAS D, PO BOX 544,67156
221-3200
39 M 4102 16 ORS
SNYDER, H MARTIN, PO BOX 544,67156
221-3200
31 M 4102 56 GS
SNYDER, HOWARD E, 1317 WHEAT RD BOX 544,671S6
-
03 M 4102 27 OO
WELLS, BRUCE W, PO BOX 643,671S6
221-3350
39 M 1902 64 IM
WHITACRE, MARC M, 11 BRAID HILLS DR,67156
221-3200
S3 M 4101 79 OPH
WHITE, R BURNLEY, 117 W 9TH,67156
221-2950
24 M 1902 52 FP
WINBLAD, J KENT, 15 FLEETWOOD,671S6
221-6100
51 M 1902 76 OBG
WINBLAD, JAMES N, 1211 E 5TH ST,67156
221-6100
27 M 1902 53 GS
WINBLAD, JOHN M, 1211 E FIFTH,67156
221-6100
S5 M 1902 B1 FP

OUT OF STATE

ADAMS, JOYCE A, 6106 HARRISON
KANSAS CITY MO 64110
AGIAR, MARY C, 948 W 33RD TERR
KANSAS CITY MO 64111
AHMED, IFTEKHAR, 2900 BALTIMORE #390
KANSAS CITY MO 64108
ALLEN, MARK L, 8301 STATE LINE SUITE 200
KANSAS CITY MO 64114
ANDERSON, LYLE B, 4745 S STATE RD #446
BLOOMINGTON IN 47401
ANDERSON, WINSTAN L, 12602 CRYSTAL LAKE DR
SUN CITY WEST AZ B5375
BACON, ARTHUR H, 38 RUBBER TREE DR
LAKE WORTH FL 33643
BARELLI, PAT A, 2929 BALTIMORE
KANSAS CITY MO 64108
BARNES, MARIAN, 2040 W AVE J-13 APT 27
LANCASTER CA 93534
BASER, ALI N, DAVID GRANT USAF MED CTR
TRAVIS AFB CA 94535
BECK JR, CALVIN E, 808 W 99TH
KANSAS CITY MO 64114
BEHRHORST, CARROLL D, MEDICO Y CIRUJANO
GUATEMALA
BENNETT, CHARLES A, 5619 NW HILLSIDE DR
KANSAS CITY MO 64151
BENNETT, S H, 3630 BELL 3RD FL
KANSAS CITY MO 64111
BLACK, WILLIAM L, 2775 BLACK DIAMOND TER
COLORADO SPGS CO 60918
BLIM, R DON, 4400 BROADWAY
KANSAS CITY MO 64111
BOLLIER, RENE P, 7490 BROMPTON APT 424
HOUSTON TX 77025
BRAUN, WILLIAM T, 163 BRANDY HILLS DR
PORT ORANGE FL 32019
BRIDGENS, JAMES G, 1025 HUNTINGTON RD
KANSAS CITY MO 64113
BROOKER, ROBERT M, 101 OCEANO AVE #19
SANTA BARBARA CA 93109
BROWN, ALEX L, 2-2340 GRECIAN WAY
CLEARWATER FL 33515
BROWN, ROBERT J, BOX 249
RUSHVILLE MO 64484
BROWN-SANDERS, CAROLINE, 617 A WILLOW DR
LEES SUMMIT MO 64063
BUDETTI, JOSEPH A, 19667 TURNBERRY WAY
N MIAMI BEACH FL 33180
BUTIN, RICHARD E, C/O CLEVELAND CI ED DEPT
CLEVELAND OH 44106
CAROUFF, JAY J, 13510 PEYTON
DALLAS TX 75240
CARREAU, ERNEST P, 545 SW SECOND CT
CEDAREDGE CO B1413
CESSNA, JAMES E, 10565 N TATUM, B116
PARADISE VALLEY AZ 85253
CHDY, JAMES K L, 12842 BALLAD DR
SUN CITY AZ 85375
CHRISTENSEN, SHANE R, A4B12 HEINTZ
KANSAS CITY MO 64133
CHRYSANT, STEVEN G, VA HOSP
KANSAS CITY MO 64128
CLARK, ORVILLE R, 911 EDEN ISLE DR NE
ST PETERSBURG FL 33704
CLARK, RAY A, 2410 2ND AVE
LAKE CHAS LA 70601
CLARK, ROBERT THOMAS, APARTADO 563
GUATEMALA CEN A *
CLAY, MICHAEL J, 1717 1/2 WESTPORT RD
KANSAS CITY MO 64111
COLLINS, JEFFREY S, 4333 OAK APT 3
KANSAS CITY MO 64111
COLYER, JEFFREY W, 1111 W 46TH
KANSAS CITY MO 64112
COOPER, LEO F, RT 2 BOX 28B
DREXEL MO 64742
CORDER, ROBERT L, 4903 STONECREST TERR
ST JOSEPH MO 64506
CRABB, JEREMIAH E, 3630 BELL
KANSAS CITY MO 64111
DAVIDNER, MARK L, 6724 TROOST #700
KANSAS CITY MO 64131
DE JONG, JOHN THEODORE, 3716 BELL
KANSAS CITY MO 64111
DE LAPP, DENNIS K, 1727 NE CLUBHOUSE DR #302
N KANSAS CITY MO 64116
DELMORE, JAMES E, 7717 CAMBRIDGE
HOUSTON TX 77064
DEVINS, GEORGE S, 6700 TROOST #520
KANSAS CITY MO 64131
DIACON, JAMES L, 45 BRITTAIN CIRCLE
BELLA VISTA AR 72712
DIEHL, ANTONI M, 4320 WORNALL RD
KANSAS CITY MO 64111
DINGES, DAVID L, 4603 BELL
KANSAS CITY MO 64112
DO, SON T, 4123 TERRACE APT 2 NE
KANSAS CITY MO 64111
DUNCAN, KIRK A, 2700 HOSP DR APT 240
N KANSAS CITY MO 64116
EHLY, CHRISTOPHER J, 5301 LYDIA
KANSAS CITY MO 64110
EMIG, MARK D, 4603 BELL
KANSAS CITY MO 64112
ENNS, JAMES H, 3520 PIONEER DR
LAKE HAVASU CTY AZ 86403
FALLON, JOHN H, 1640 CAPITOL
INDIANAPOLIS IN 46202
FANSHIER, SHAWNETTE L, 3739 GENESSE
KANSAS CITY MO 64111
FERNIE, ROBERT W, 3100 N BROADWAY #208
BOULDER CO B0302
FESTOFF, BARRY W, VA HOSPITAL
KANSAS CITY MO 64128
FINK, ABRAHAM A, 305 JACARANDA DR
PLANTATION FL 33324
FISHER, RONALD M, 157 MORNINGSIDE RD
SCOTLAND *
FLANDERS, H ALDEN, UNIT 4 - 34
EDINBURGH TX 78539
FRECHETTE, ALAN R, 3560 BROADWAY #506
KANSAS CITY MO 64111
FRITZ, GEORGE E, RR 1 BOX 53
KEWADIN MI 49648
GAUME, JAMES G, 2550 VIA TEJON STE 3H
PALOS VERDES CA 90274
GENCH, RAYMOND L, HACIENDA CARMEL #83
CARMEL CA 93921
GENTRY, JAMES H, 950 E HOWARD
DENVER CO B0210
GESSLER, DONALD J, CIGNA HLTH PLAN OF TEXAS
HOUSTON TX 77057
GILL, GEORGE L, PO BOX 255
LAMPE MO 65681
GLATTER, THOMAS R, VA HOSPITAL
KANSAS CITY MO 64128
GODFREY, WILLIAM A, 4320 WORNALL RD
KANSAS CITY MO 64111
GOODPASTURE, WILLARD C, 1591 W PLACITA GARBO
GREEN VALLEY AZ 85614
GRAHAM, WALLACE H, 6724 TROOST SUITE 304
KANSAS CITY MO 64131
GUASTELLO, MARIO J, 4320 WORNALL
KANSAS CITY MO 64111
GUTTIKONDA, PRASAD B, 548 GYPSY LANE SUITE B
YOUNGSTOWN OH 44505

HAGMAN, JENNIFER D, 4455 JEFFERSON #14
KANSAS CITY MO 64111
HAMILTON, WILLIAM A, 3730 WYOMING
KANSAS CITY MO 64111
HAMM, ORVAL L, MEMORIAL CHRISTN HOSP
PAKISTAN
HANOS, SEBEL V, 2418 W EIGHTH
AMARILLO TX 79102
HANSEN, DANIELS D, 41509 E FLORIDA
HEMET CA 92344
HARO, BENJAMIN F, BOX 4913 HAWTHORN RD
KANSAS CITY MO 64120
HARTLEY, FOUNT K, UNIVERSITY OF FLORIDA
GAINESVILLE FL 32610
HARVEY, JEAN A, 3353 LOMBARDY LN APT 308
DALLAS TX 75220
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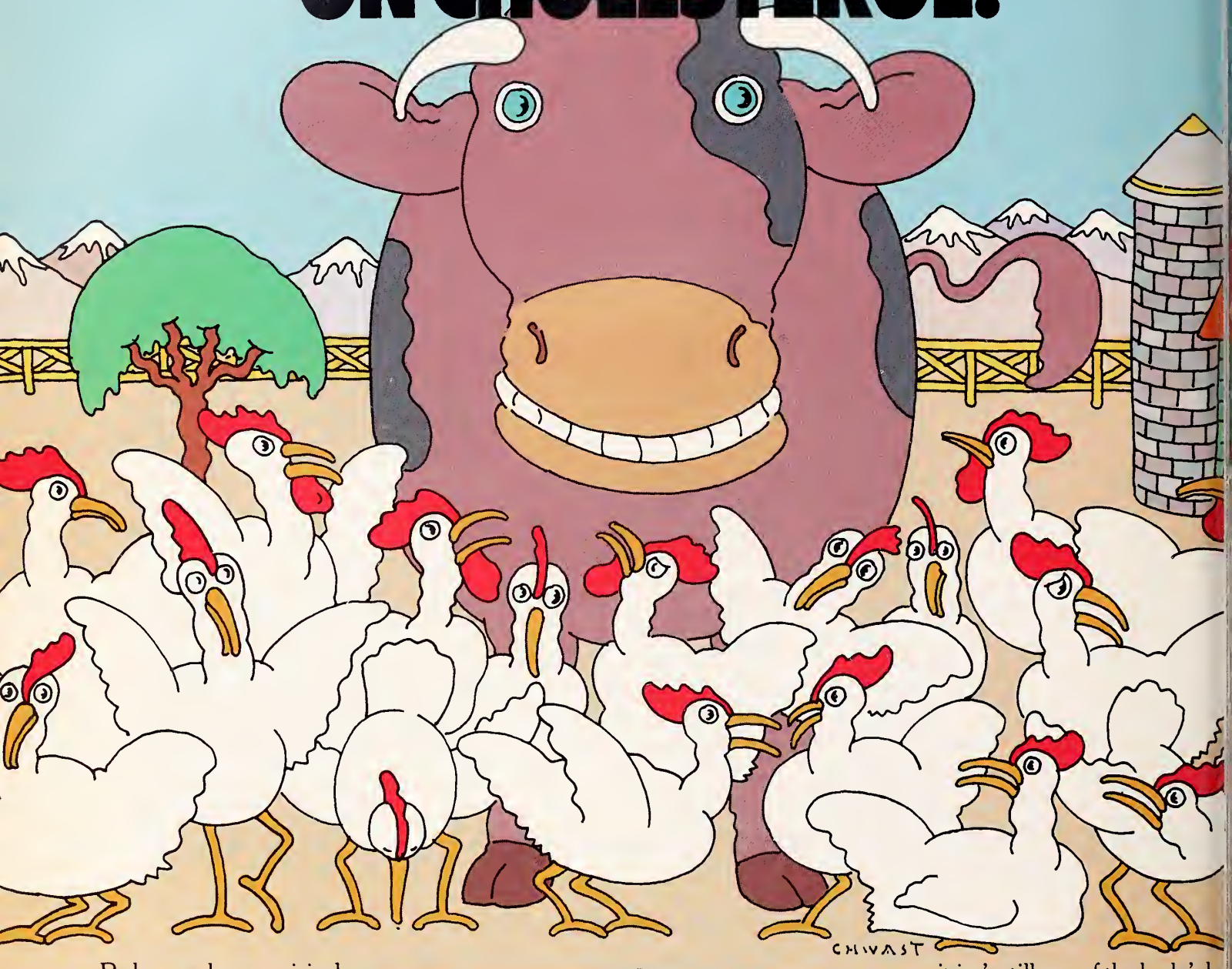
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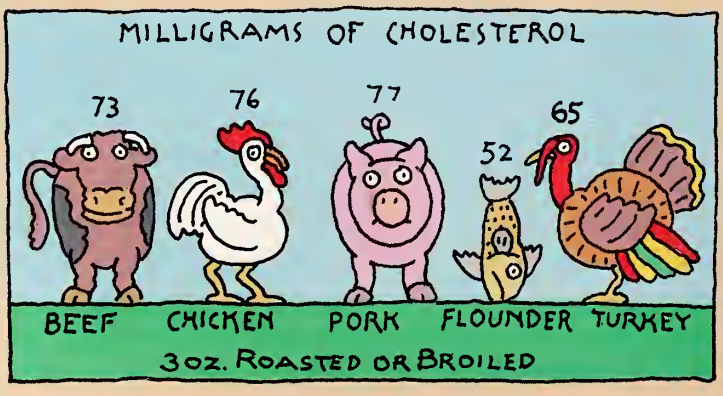
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For a free reprint of this a or additional information on the new U.S.D.A. beef study, write to: Department of Research and Nutrition Informatio National Live Stock and Meat Board, 444 North Michigan Avenue, Chicago, Illinois 60611.

*Beef data from 1983 Beef Nutritive Composition Studies conducted by the U.S.D.A. and National Live Stock and Meat Board.

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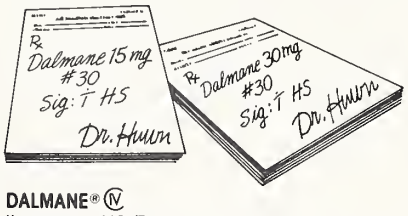
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KANSAS MEDICINE

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KANSAS MEDICINE

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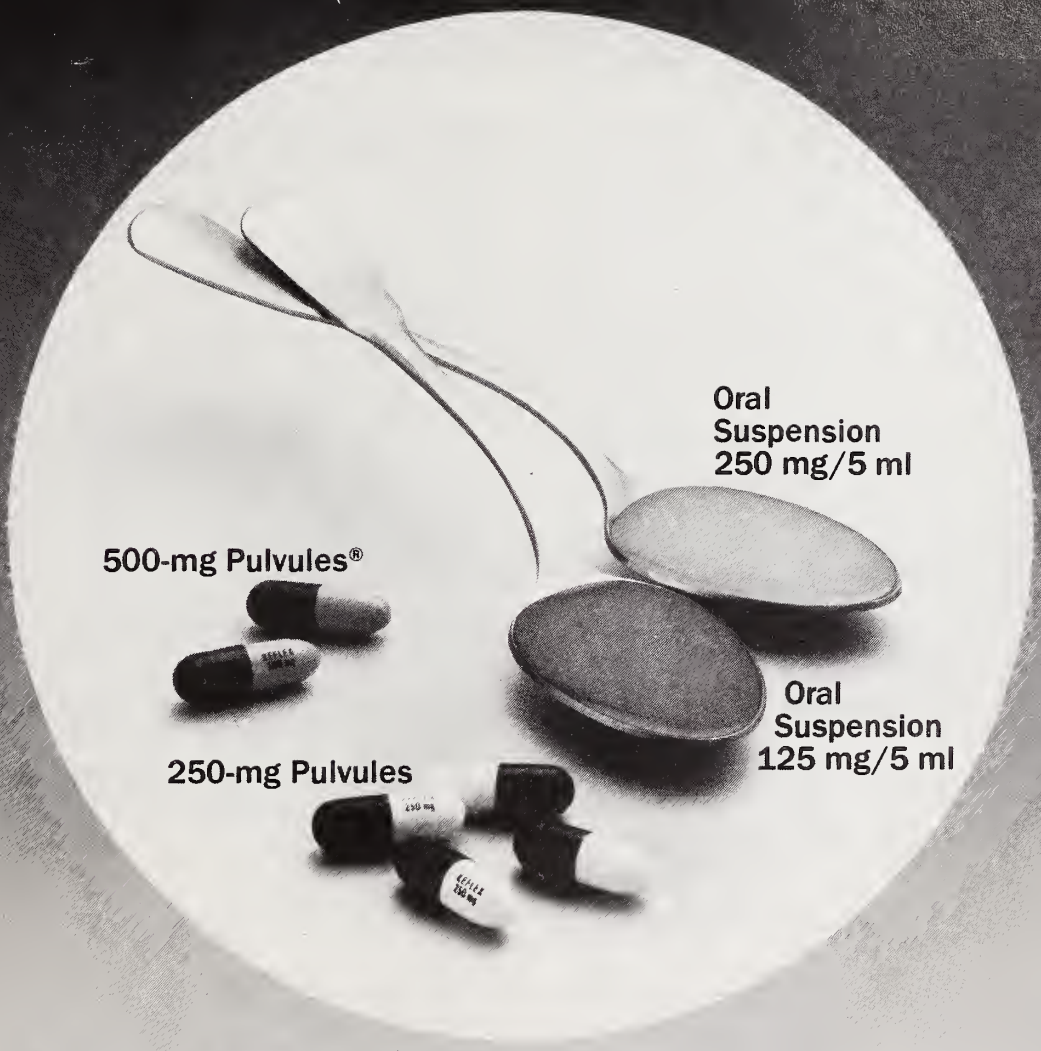
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AMA DELEGATE REPORT

Unified Membership

Editor's Note: The 1985 House of Delegates adopted Resolution #85-12 that mandates unified county-state-national membership effective January 1, 1986. This is the fourth in a series of short messages to Kansas physicians presented by members of the Kansas AMA delegation.

In May, the Kansas Medical Society House of Delegates adopted Resolution 85-12 calling for Kansas to become a unified membership state in 1986. By now, KMS members know that upon joining the local county society and the Kansas Medical Society, they will also join the American Medical Association.

The additional cost of AMA dues — about one dollar a day — is a small amount to pay for what the AMA accomplishes for you in accrediting not only medical schools, but also graduate medical education and continuing medical education programs. The Council on Medical Education on which I serve and the Association of American Medical Colleges (AAMC) form the Liaison Committee for Medical Education (LCME) which accredits all U.S. and Canadian medical schools. By maintaining very high standards for medical education, LCME has brought the American medical education system to be the worldwide model. In addition, the Council on Medical Education assists in the accreditation of all residency programs as well as programs in continuing medical education.

This very important work in undergraduate, graduate, and continuing medical education helps maintain the system in which we have all been educated, trained, and continue our education while in practice. The costs of these activities are very high as more than 100 staff members are employed by the AMA to maintain these vital accrediting agencies and committees. We need *your* support, both financial and professional, to help the AMA continue this important work; without it, medical education and graduate medical education in the United States would be chaotic, or nonexistent.

As others before me have said on these pages, the benefits of AMA membership far exceed the small additional cost for dues. I join our KMS President, Dr. Clair Conard, others from the Kansas Medical Society, and your AMA delegation in urging you to join the American Medical Association in 1986 and help us in our great work of maintaining a proud and unified profession in the United States.

William J. Reals, M.D.
AMA Delegate,
College of American Pathologists

Fighting the Crisis

The crisis in professional liability for physicians — after a respite of a few years — has resurfaced with a vengeance. In fact, the liability problem may be *worse* today than in the mid-1970s when medical malpractice insurance first began making headlines. At its most severe, the medical liability crisis of nearly a decade ago resulted in a shortage of coverage for physicians. Now the crucial insurance problem for physician seems to be this: coverage is available, but premiums are going so high that some practitioners avoid them by withdrawing their services in whole or in part, or by taking early retirement. As a result, of course, patient access to medical care is restricted, and that makes physicians' professional liability everyone's crisis.

In battling this recurrent crisis, one of the initiatives of the American Medical Association is its Special Task Force on Professional Liability and Insurance. The first goal of the task force was to determine the severity of the liability problem, which it summarized in a report issued in the autumn of 1984. After the release of that report, the task force chairman, AMA Executive Vice President James H. Sammons, M.D. said:

> What is now developing is a crisis in affordability for physicians. In the mid-1970s, when the first big

wave of claims engulfed the medical profession, many commercial insurers deserted the market. New physician-owned companies were launched — companies that now provide protection to more than half the profession. Some commercial companies have stayed in the market, and a few others are moving back into it. Insurance is available, but its price is rising. The question is, how long can physicians afford to pay that price?

The current escalation in physicians' premiums couldn't have come at a worse time, when the public's and policymakers' sensitivity about medical costs is at high pitch. All physicians have reason to be worried about the cost of professional liability. Consider these few points from the first report of the special task force and other sources:

- The number of 1984 claims against physicians' insurance is projected to reach about 40,000, up from 32,534 in 1983. There were 14,074 such claims in fiscal year 1976 — the midst of the "medical malpractice crisis";
- One survey indicates that, because of the ruinous insurance rates, 9% of OB/GYN specialists have given up the practice of obstetrics entirely and 20% avoid high-risk pregnancy cases;
- The loss in productivity among physicians who have taken early retirement rather than pay high premiums has been placed at $250 million annually, according to the AMA.

The end result, the AMA task force concluded, is a professional liability system that is "ever more costly financially, and one that undermines physician-patient relationships and ultimately drains strength from the entire medical care system in the nation."

What can be done about the professional liability crisis?

The AMA special task force has made a substantial start in its intensive and crucial effort. The task force's first report provides the information and perspectives necessary to carry out its mandate — coordinating the AMA's activities with regard to professional liability (including those of the AMA's Committee on Professional Liability) and developing a plan of action to respond to the crisis. Other important task force efforts:

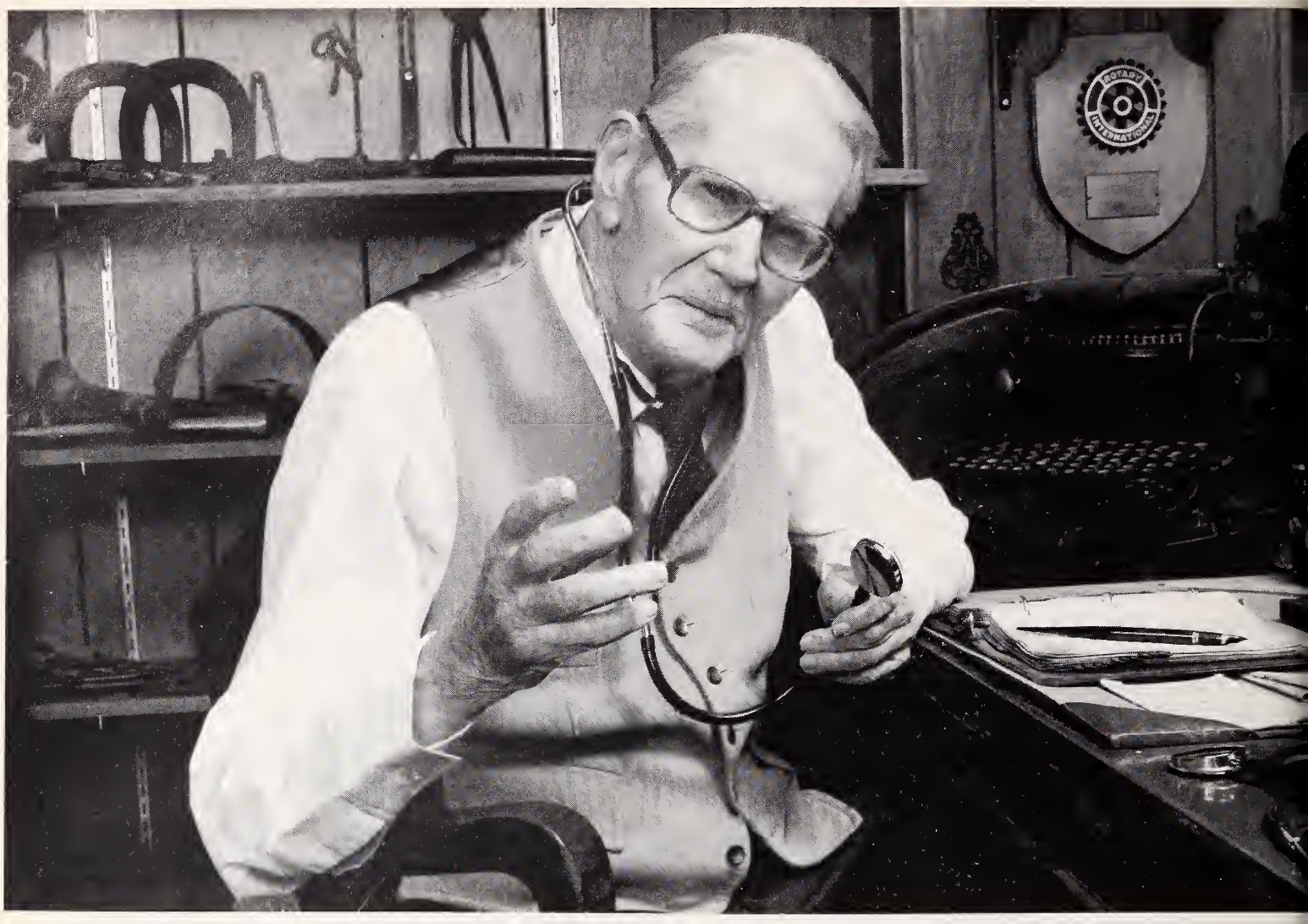
- An assessment of the professional liability insurance market;
- A review of tort reforms;
- An evaluation of possible solutions needed for the plan of action;
- Compiling information on risk management in cooperation with the American Medical Assurance Co. (AMACO), the AMA's insurance subsidiary;
- Actively promoting state coalitions to address the issue of tort reform;
- Development of a pamphlet, for distribution in physicians' offices, to educate patients on professional liability;
- Creating a publication for physicians, including useful information on avoiding professional liability suits;
- Installation of toll-tree AMA phone numbers to handle inquiries from physicians or the general public on professional liability. Those numbers are: 800-552-4642 and, in Illinois, 800-821-5309;
- Approval by AMACO of grants to study important medical liability topics.

Given that professional liability for physicians is a nationwide problem that varies according to individual state laws — and that it is a crisis facing all physicians — the AMA's national leadership role is vital. And so is your support of the AMA on this front.

There are a number of reasons behind the medical liability crisis. Among those cited by the AMA task force are: the increasing complexity of medical technology (which has brought about some new procedures that increase risk of injury); high public expectations regarding medicine; a more litigious society; and a larger number of attorneys who are willing to file frivolous suits.

Yet, whatever will be the solution to the crisis, a good guess is that it will involve physicians working together. In the 1970s, when commercial coverage was difficult to obtain, physicians banded together to form their own insurance companies. Formation of many of these companies might well have been impossible had the AMA not formed AMACO to provide reinsurance. The AMA has shown many times on this and other medical issues, that a united, national front serves medicine well.

Moreover, the Association supports professional excellence in numerous ways, providing an important counterforce to actual malpractice. And through the special task force's clear examination of liability problems and its development of a practical agenda for action as well as through other activities in the professional liability arena, physicians stand the best chance of seeing this crisis end.



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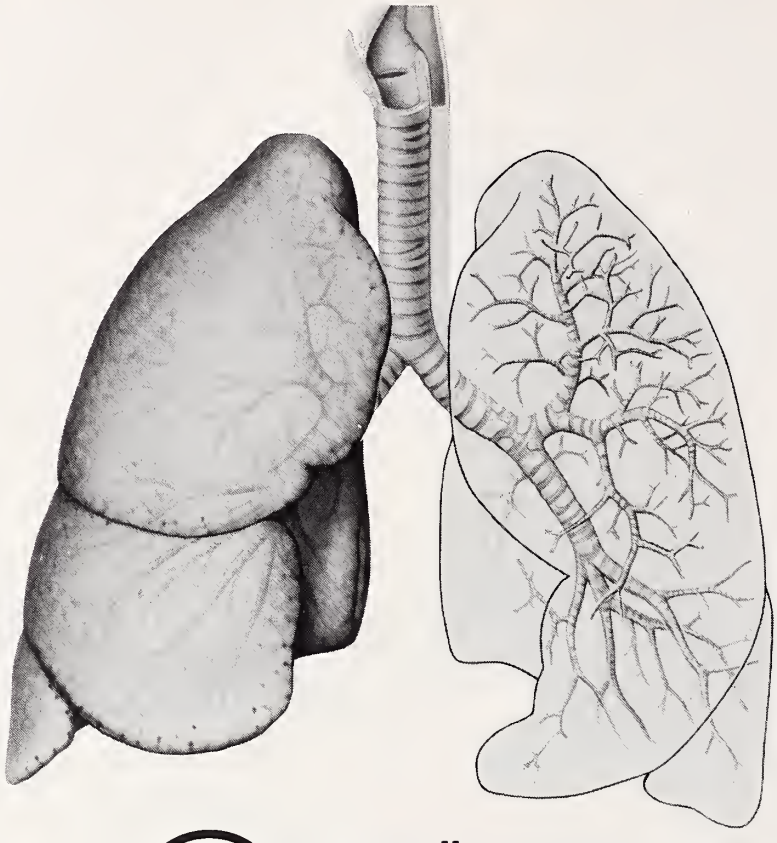
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Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

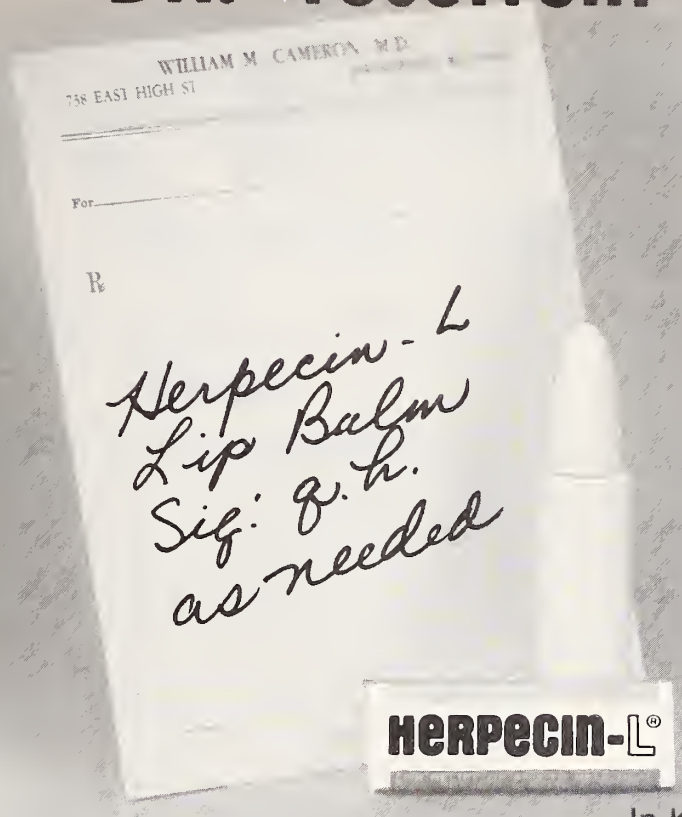
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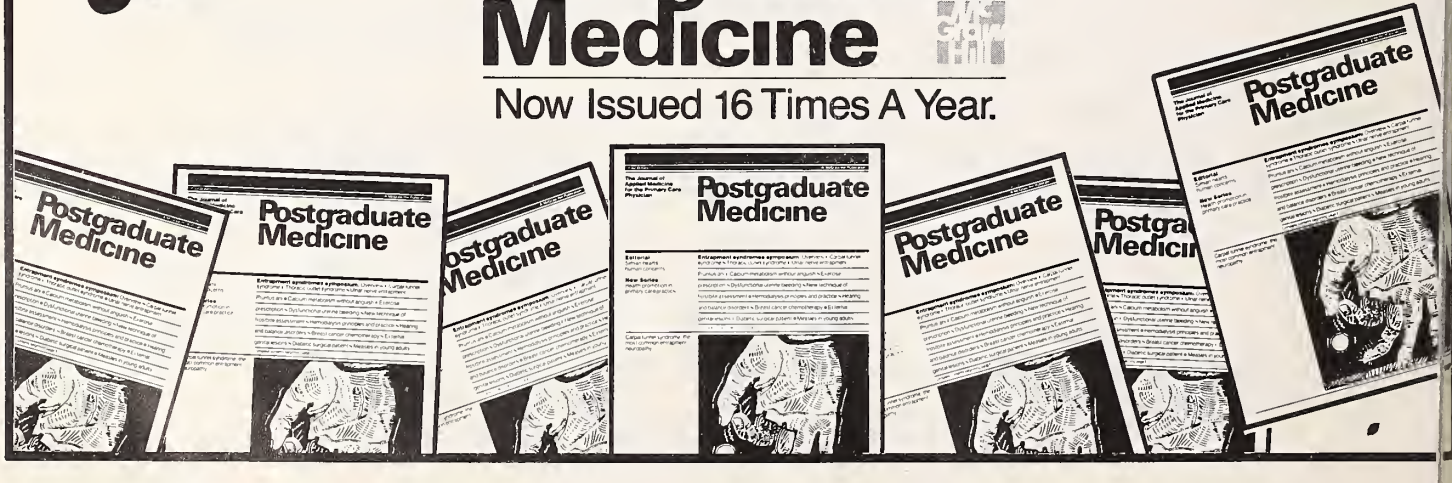
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SCIENTIFIC ARTICLES

Shaw Hemostatic Scalpel

ERIC M. PECK, M.D.; SHARON CATES, R.N. *and* **KERMIT E. KRANTZ, M.D.,**
Kansas City, Kansas

The Shaw Hemostatic Scalpel System (Oximetrix, Inc.) conducts heat from a sharp, temperature-controlled blade that seals blood vessels as tissue is cut, permitting hemostatic incisions with the precision of conventional steel scalpels. The surgeon may vary the temperature of the scalpel between 110 and 270 C. This is not an electrical current system; no grounding plates are required. Small blood vessels are sealed during incision by thermal cauterization, so — unlike electrocautery — there is minimal tissue damage.

After two years of use at the Kansas University Medical Center, it was the general impression of gynecologic surgeons that use of the Shaw scalpel significantly reduced blood loss during vaginal hysterectomy. The present study was designed to test this hypothesis.

Materials and Methods

Between July 1983 and May 1984 patients scheduled to undergo vaginal hysterectomy were offered the opportunity to participate in the study. Consenting patients were randomized to either the Shaw hemostatic scalpel or the traditional "cold" scalpel. The scalpel was used to make a circumferential incision through the vaginal mucosa and muscularis surrounding the cervix uteri. This was the only step of the procedure in which a scalpel was used. The remainder of the dissection was performed with scissors, and was identical for both groups of patients. Sponges were weighed after the initial incision and prior to placement of the first clamp, *i.e.* the cardinal ligament pedicle. This was labelled "cuff blood loss." Blood loss was again estimated at the end of the procedure and labelled "total blood loss." Patients were excluded from the study if laparotomy was required.

Results

Forty-two patients participated. Twenty patients were randomized to the Shaw scalpel and 22 patients underwent initial incision with the traditional scalpel ("cold knife"). Total blood loss for patients operated on with the traditional scalpel ranged from 150 to 1600 cc, with a mean estimated blood loss (EBL) of 444 cc. For patients on whom the Shaw hemostatic scalpel was used, total estimated blood loss ranged from 110 to 900 cc, with a mean EBL of 415.3 cc. This represents a reduction of 28.7 cc of bleeding, or a decrease by 6.5% of total intraoperative blood loss. Mean "vaginal cuff blood loss" was 27.6 cc for patients randomized to the Shaw scalpel and 45.0 cc for the patients on whom the cold knife was used. This represents a savings of 20.4 cc. A comparison of procedures with the two scalpels is shown in *Table I*.

Two patients who were randomized to the Shaw scalpel were transfused with a total of three units of blood postoperatively, while only one patient in the cold knife group required one unit of blood.

Of the patients operated on with the Shaw scalpel, nine of 20 had postoperative temperatures of 38 C or greater: on the first postoperative day the average temperature of eight patients who had fevers was 38.2. One patient had a fever on both the first postoperative day and the day of surgery, while another had a fever on both the second and third postoperative days. Of eight patients who had postoperative fevers in the "cold knife" group (eight of 22), three had temperatures averaging 38.3 on the first postoperative day, three had temperatures averaging 38.5

TABLE I
BREAKDOWN OF CASES

	With Shaw	With Cold Knife
Total vaginal hysterectomy (TVH)	13	17
TVH with anterior repair	0	1
TVH with posterior repair	2	0
TVH with anterior and posterior repair	4	2
TVH with laparoscopy done first	1	2
Total	20	22

From the Department of Gynecology and Obstetrics, The University of Kansas School of Medicine-Kansas City.

TABLE II
FEBRILITY

	Day of Surgery	POD #1	POD #2	POD #3
With Shaw scalpel	1	8	1	
With cold knife	2	3	3	2

on the second postoperative day. Two patients had fever on the third postoperative day, with average temperatures of 38.2. Two patients had fever on the day of surgery. Comparative febrility data are shown in *Table II*.

Discussion

Both the range and the mean total estimated blood loss were lower for patients who underwent vaginal hysterectomy with the Shaw hemostatic scalpel than for those on whom the traditional scalpel was used in this randomized prospective comparison. The reduction in blood loss did not reach statistical significance. Most of the reduction in blood loss was from the vaginal cuff bleeding as would be expected since this was the only step in which the scalpel was used. Use of the Shaw scalpel did not reduce the number of blood transfusions ordered. Total numbers of febrile patients postoperatively were approximately the same for two groups, but patients who became febrile after use of the cold knife were more likely to have had a fever on the second and/or third postoperative day, and their temperatures were in general higher. This may represent a tendency for a decrease in the number of mild postoperative vaginal cuff cellulitides when the Shaw scalpel is used.

The Shaw hemostatic scalpel may be of benefit in decreasing blood loss and postoperative infection in vaginal hysterectomy, but larger controlled trials are necessary to demonstrate this.

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Percutaneous Transluminal Coronary Angioplasty

SATYA N. HEBBAR, M.D.; ALLEN L. GUTOVITZ, M.D.;
O. WARREN MEYER, M.D. *and* DONALD H. JACKSON, M.D., *Topeka*

Atherosclerotic coronary heart disease is the most common cause of death in the United States, despite major emphasis on disease prevention. Palliative measures either with medical therapy or coronary artery bypass surgery still remain the mainstay of treatment. Since its first application to humans in 1977, percutaneous transluminal coronary angioplasty (PTCA) has emerged as an alternative therapy to medicines and coronary artery bypass surgery (CABS). With time, PTCA has undergone rapid technical evolution and today it is considered the method of choice in some patients with symptomatic coronary artery disease. Because PTCA is a less invasive technique than bypass surgery, there has been a rapid increase in its use. It is estimated that 25,000 to 30,000 PTCA procedures will be performed annually across the country. The present study is a review of our experience with PTCA.

Technique and Mechanism

The technique of balloon dilatation of coronary artery lesions has been discribed in detail. Approach to the coronary arteries is either by percutaneous femoral artery puncture or by brachial artery cutdown.[1] We have used the femoral artery approach exclusively. A recent advance in the technique of PTCA has been the development of steerable balloon dilatation catheters.[2] With the use of a steerable system, coronary angioplasty has become easier and safer, particularly in dilatations of distal coronary lesions, very tight coronary lesions, and lesions previously inaccessible. Successful dilatation is identified by a drop in the transtenotic gradient ideally to less than 20 mm Hg and a 20% or greater reduction in stenosis diameter. The technique of balloon inflation varies as to the number of inflations, their duration, and pressure developed. The current trend is to carry out a few prolonged inflations rather than multiple inflations of shorter duration.

The objective of PTCA is to safely increase the luminal diameter in a stenotic coronary artery segment, thereby improving coronary blood flow. Initially, it was thought that compression of the atheromatous plaque was responsible for the enlargement of the coronary artery lumen following PTCA.[1] Subsequent studies revealed that angioplasty produced intimal splitting without true compression. This controlled injury of the arterial wall helps to explain the "fuzzy" angiographic appearance frequently observed at the angioplasty site after successful dilatations.[3] In addition to the intimal splitting, medial and adventitial stretching may play a major part in the immediate enlargement of the luminal diameter. The latter mechanism helps explain the rationale for the longer balloon inflations. Further reduction of the stenosis may result during the healing process.

Indications

Proper selection of a patient for PTCA has a significant impact upon the success rate and the incidence of complications. The ideal patient has high grade single vessel stenosis and angina pectoris, objective physiologic evidence of myocardial ischemia, and be a suitable and willing candidate for CABS. The lesion itself should be proximal, concentric, and without calcification. The findings of increased lesion severity (>90% stenosis), lesion calcification, and distal and non-left anterior descending artery lesions correlate with a lower success rate. Right coronary artery lesions and circumflex lesions located at a point of marked curvature or beyond regions of great tortuosity may be poor candidates for PTCA and result in dissection and occlusion soon after apparent initial success. Thus success rates are lower and complication rates higher in the right coronary artery and circumflex arteries than in the left anterior descending artery. With newer balloon catheters, this is becoming less of a problem.

Most of the candidates for PTCA have single vessel disease and are commonly considered to have a good prognosis. It has been shown that more than one-third of the survivors of a myocardial infarction had single vessel disease. However, patients with single vessel disease do not represent an homogenous population. Some patients may have a poorer prognosis and a more urgent need for in-

Address reprint requests to Dr. Hebbar, Cardiology Consultants of Topeka, P.A., 634 Mulvane, Suite 100, Topeka KS 66606.

tervention, particularly if the stenosis is located proximally with a large amount of myocardium at risk. The need for PTCA in these patients must be judged individually on the basis of clinical course, amount of myocardium in jeopardy, and angiographic morphology of the lesion.

Contraindications

A number of angiographic findings may be relative contraindications for PTCA. Because of the large amount of myocardium at risk in case of complication, left main stenosis is considered a relative contraindication. Other relative contraindications include the presence of an old occlusion, a calcified stenosis, and provokable coronary spasm.

The reported incidence of emergency CABS and myocardial infarction during PTCA in patients with mild coronary artery disease is similar or higher than in patients with severe disease. In addition, the severity of restenosis when it occurred exceeded the initial degree of stenosis. Therefore, it has been recommended that PTCA not be attempted in mild disease. On the other hand, if many vessels are dilated with mild disease, the success rate can also be falsely elevated.

Clinical Study

Our patient population consisted of 113 males and 45 females during a three-year period from January 1981 to December 1984. The majority of these patients (76%) had predominantly single vessel disease. Two vessel disease was present in 20% and left main stenosis in 3% of the patients. Of the dilatations, 62% were left anterior descending, 28% right coronary, 5% circumflex, 3% left main, and the rest consisted of grafts and major branches. Primary angiographic success was achieved in 76% of patients in the three-year period. This experience is reflective of a learning curve with improved primary success rate of 87% in the third year. Gruentzig initially reported a 66% primary success rate, whereas in his most recent experience success is reported to be in excess of 90%.[4] Most reported clinical series have a primary success rate between 60 and 80%.

The effectiveness of PTCA has been confirmed by many studies using exercise testing, some including radionuclide studies.[5] Subsequent abnormalities on retesting may be predictive of restenosis. We have followed nearly all of our patients with a regular treadmill test two weeks following angioplasty and have used this as a control for future treadmill tests for followup.

Complications

PTCA is associated with a major or minor early complication in 21% of patients. Major complications may include death, non-fatal myocardial infarction, or the need or emergency bypass surgery.[8] Coronary dissection or occlusion and prolonged angina are most common indications for emergency CABS. In our series, emergency CABS was required in 7.6% of patients. Myocardial infarction in general is prevented if surgical reperfusion is accomplished within 30 minutes and minimized if reperfusion is achieved within 30 to 120 minutes. We have been able to achieve reperfusion with surgery in an average of 45 minutes. It is important that a surgeon and operating room be on immediate standby during PTCA procedure.

In Gruentizig's recent experience with 114 patients, there was successful dilatation in 96% without any myocardial infarction or emergency bypass surgery.[4] Thus the need for surgical standby may decrease in the future. Our experience during three years is similar with the need for surgery standby decreasing. We do believe, however, that strong cooperation and excellent communication between cardiologists and cardiac surgeons is vital.

Restenosis is a major late complication following successful PTCA, occurring in about 30% of patients. Of these, perhaps two-thirds become symptomatic and require treatment. Angiographically, it is defined as a reduction by 50% of the initial improvement in luminal diameter. In our experience, 10% of patients have developed clinical restenosis presenting with reappearance of symptoms, reoccurrence of ischemia on repeat treadmill testing, or restenosis on angiography. The cause of restenosis is uncertain. There is no clear-cut benefit provided by any particular post-PTCA treatment regimens, although all of our patients have been placed on aspirin for inhibition of platelet aggregation and nifedipine for prevention of coronary spasm. Repeat PTCA is very effective in patients with restenosis. Long-term success rates in patients who undergo a repeat PTCA procedure appear even better than those seen after initial dilatation. The accessibility and distensibility of the narrowed segment in these patients has already been tested during the first dilatation.

Expanded Indications

As experience and technology have grown during the past several years, so has the spectrum of candidacy for coronary angioplasty. Application of PTCA has expanded to patients who have multivessel disease, stenotic bypass grafts, and lesions for which surgical intervention is technically more

(Continued on page 276)

Tracheal Carcinoma

RANDALL R. BEECH, M.D.*; SULEMAN SADIQ, M.D.† *and* DANIEL A. TATPATI, M.D.†, *Wichita*

MALIGNANT primary tumors of the trachea constitute a comparatively rare group of lesions whose clandestine clinical course present a medical and surgical challenge.

Lieutaud, in 1767, described a fibroma of the trachea as an incidental autopsy finding, but it wasn't until 1871 that Langhans reported the first primary carcinoma of the trachea defined by histologic study.[1] Since this time, diagnostic and therapeutic methods have improved; however the natural history of such tumors is, at best, only partially defined.

Primary carcinoma of the trachea has seldom been diagnosed early in its clinical course. Nonspecific symptoms and absence of radiologic signs have contributed to the delay in diagnosis.[2]

The following is a case report illustrating the above points. A review of the literature and management of this rare tumor will be discussed.

Case Summary

A 60-year-old patient was admitted to our hospital with a history of productive cough and dyspnea. The patient also related a progressive history of periods of "difficulty getting air in" during the preceding six months. The patient denied weight loss or systemic symptoms such as fever, chills, or night sweats. The patient's past medical history was significant for prior myocardial infarction, hypertension, adult onset diabetes mellitus, and chronic obstructive pulmonary disease. The patient also had a 120 pack-year smoking history.

Admission physical examination noted the patient to be afebrile and in no acute distress. Coarse rales were heard bilaterally in the lower lung fields but no rhonchi, wheezing, or stridor were detected. Admission white blood count was 16,500 with no accompanying left shift. Admission chest x-ray revealed no pulmonary infiltrate but was compatible with chronic obstructive pulmonary disease *(Figure 1)*. Sputum cultures were obtained and the patient was placed on a broad spectrum antibiotic and vigorous pulmonary toilet. The admission diagnosis was acute bronchitis with exacerbation of the patient's chronic obstructive pulmonary disease.

By the third hospital day, a chest x-ray demonstrated a right basilar infiltrate. On the fifth hospital day the patient was in significant pulmonary distress with increasing dyspnea and deteriorating arterial blood gases. Consultation was sought from our cardiothoracic surgery service for therapeutic bronchoscopy.

The patient was prepared for bronchoscopy under local anesthesia. Shortly after being premedicated, the patient suffered a respiratory arrest.

The patient was immediately intubated and resuscitated. Bronchoscopy was performed and thick

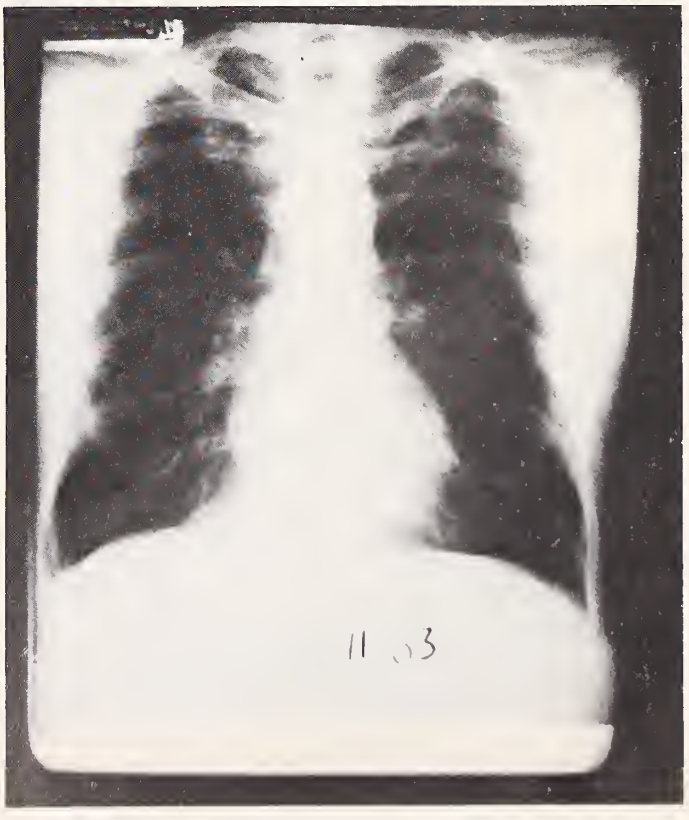


Figure 1. The chest x-ray demonstrated only changes compatible with chronic obstructive pulmonary disease.

From the Department of Surgery, The University of Kansas School of Medicine-Wichita, and St. Francis Regional Medical Center, Wichita.

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†Clinical Assistant Professor, Department of Surgery, UKSM-Wichita.

Presented at the Annual Meeting of the Kansas Chapter of The American College of Surgeons, September 1984, Wichita.

Address reprint requests to Dr. Tatpati, UKSM-Wichita, 1010 No. Kansas, Wichita KS 67214.

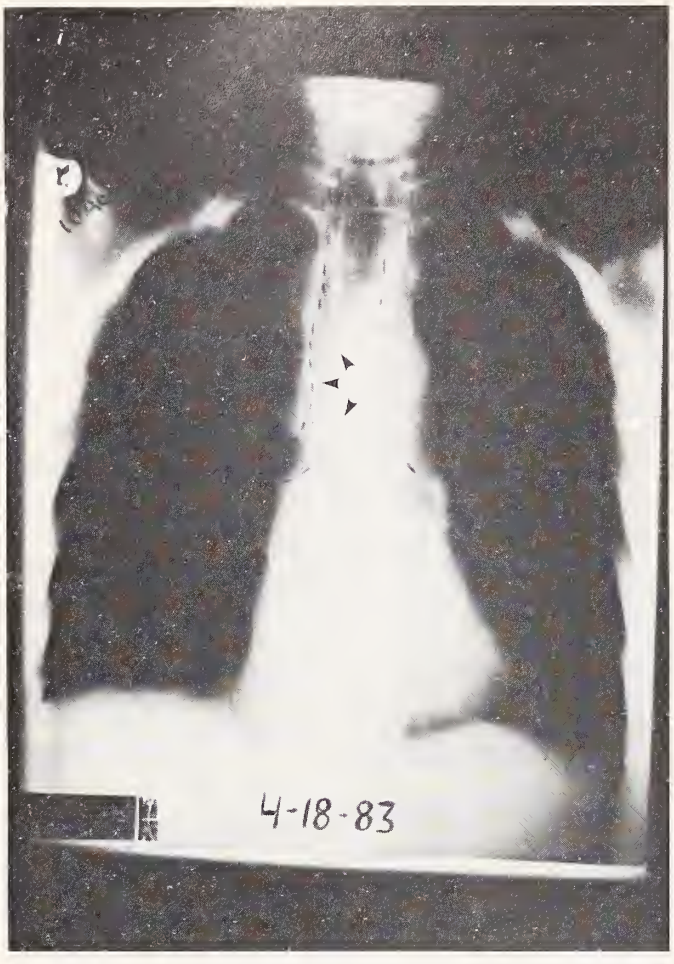


Figure 2. Tomograms of the mediastinum noted the dimensions and position of the tumor mass in the trachea.

mucopurulent secretions were suctioned from the trachea. Examination of the trachea revealed a fungating growth noted to be 3-4 cm in width projecting from a 2-3 cm wide base involving the posterolateral wall. The tumor was located approximately 1-2 cm from the carina and occluded 90% of the tracheal lumen. In addition, the right and left mainstem bronchi were filled with thick mucopurulent sputum. Results of evaluation of the rest of the pulmonary tree were unremarkable except for inflammatory changes of the mucosal lining and thick sputum. Multiple biopsies of the lesion were taken and the endotracheal tube was left in place for airway access and to facilitate pulmonary toilet.

The biopsy report revealed squamous cell carcinoma of the trachea. Lung and mediastinal tomograms documented only the solitary lesion of the trachea *(Figure 2)*. During the next two days, multiple bronchoscopies were needed to clear thick secretions that were contributing to the patient's respiratory dysfunction.

On the seventh hospital day, the patient underwent right posterolateral thoracotomy, resection of the primary tracheal tumor, and primary tracheal anastomosis *(Figures 3, 4)*. Postoperatively, the patient required mechanical ventilatory assistance for three days and, despite multiple therapeutic bronchoscopies, the patient developed a right lower lobe pneumonia. The pneumonia resolved with vigorous pulmonary toilet treatment and use of a broad spectrum antibiotic. The patient had no further complications during his postoperative course and was dismissed on the 17th postoperative day in good condition.

Pathologic diagnosis of the resected specimen revealed a fungating squamous cell carcinoma extending through the tracheal cartilaginous rings into the adjacent paratracheal tissue *(Figure 5)*. The margins of the resection were also noted to be involved with tumor.



Figure 3. This figure illustrates the (A) trachea proximal to the resection margin and (B) the bifurcation of the major bronchi with selective intubation of the right main stem bronchus during the initial tumor resection.

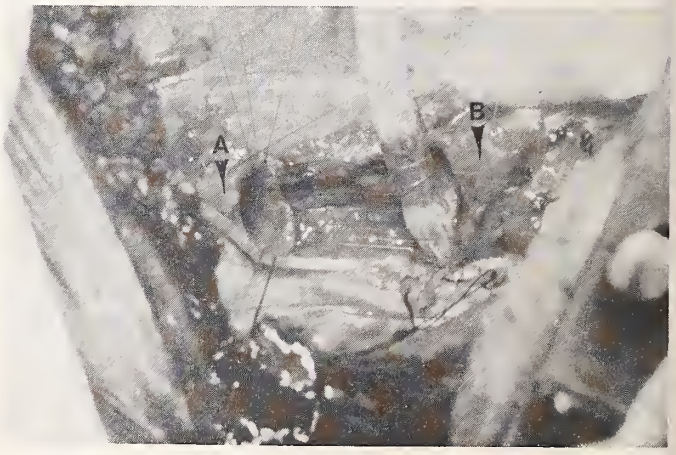


Figure 4. The right main stem bronchus was selectively intubated during the process of suture placement for reanastomosis of the (A) proximal and (B) distal trachea (depicted by the arrows).

KMS

KANSAS MEDICAL SOCIETY
Newsletter

SEPTEMBER 1985

1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

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MALPRACTICE UPDATE

The current data are in, and the results are staggering. The total malpractice premium paid by Kansas doctors and hospitals in Fiscal Year 1986 is estimated to be $48.5 million, almost 4.5 times the $11 million paid in FY 1982. The number of claims filed continues to increase at an alarming rate. It is conservatively estimated that there will be 300 malpractice claims filed during this fiscal year, up from 26 in 1979, almost a 12-fold increase. The amount of money paid to claimants is also spiraling. It is estimated that over $22 million will be paid in awards and settlements during 1985, up from $3.6 million in 1980, a 6-fold increase. During that same time period, the average size of paid claims has gone from $23,700 per claim to $113,800 per claim.

The legislature's Special Interim Committee on Medical Malpractice just concluded its fourth round of hearings on the problem. At its next meeting, October 10 and 11, the committee is expected to begin sorting out the various proposals and recommendations. Although it is a little early to make any firm predictions, there seems to be growing sentiment to adopt key aspects of the KMS/KHA proposal. Called the "Indiana Plan" it contains limits on awards, mandatory screening panels, itemization of awards, and regulated contingency fees.

The interim committee is also looking at several proposals which would strengthen the disciplinary process in the Board of Healing Arts. The Board has been criticized for being lax in disciplinary matters, and it is likely that the committee will recommend bills to improve hospital peer review and Healing Arts Board disciplinary functions.

The interim committee is expected to finish its study and make its formal recommendation around the middle of November. The committee report will undoubtedly carry great weight with the 1986 Legislature, as malpractice promises to be one of the key issues next session.

RECORDKEEPING RULES

Responding to a groundswell of opinion, the U.S. Congress has repealed the contemporaneous recordkeeping requirements pertaining to deductions for business use of automobiles and certain other property. Previously, Congress and the IRS had changed long-standing policy to require that written, contemporaneous reocrds were required to substantiate claimed business use of automobiles.

Under the new statute, corroborating evidence need not be contemporaneous or in writing. However, Congress did make it clear that written records will be accorded more weight than oral evidence, and that uncorroborated statements of the taxpayer are insufficient by themselves.

MEDICAL RECORDS

Under what circumstances may a physician refuse to provide a patient with access to his/her medical records? The only instance in which such action would be justified is when the physician "reasonably determines that the information is detrimental to the physical or mental health of the patient or is likely to cause the patient to harm himself or another." In such instances, the physician must supply the information requested to a third party or another health care provider designated by the patient. This entity in turn may release the requested information to the patient.

Amo AMA!

You needn't look for any bumper sticker proclaiming this message but you will want to look for the next issue of KANSAS MEDICINE which will be devoted to the activities of the AMA. The issue, though perhaps less lyrical than this headline, will examine that organization in depth.

ATTESTATION STATEMENTS

A recent clarification by the Kansas Foundation for Medical Care (KFMC) concerning the physician's signature on the Medicare Attestation Statement reveals that attending physicians may use initials if these can be documented to be their legal signature. If any physicians on the hospital staff use their initials as their legal signature, the hospital must ask the physician to document his/her signature on paper with a statement verifying that this indeed is his/her legal signature. The hospital further must submit such signature to the appropriate KFMC review coordinator. Such original document will then be placed in the KFMC files and a copy will be kept by the review coordinator for review purposes.

HOSPITALESS SOCIETY

A recent review of the Minneapolis/St. Paul area, the birthplace of HMO, shows that during a 34-week study period between 1983 and 1984, the hospitals dropped almost 16% of acute hospital days. The average occupancy now is 46% with some hospitals at occupancy levels below 30%. HMO enrollment has reached over 710,000 in six plans with a 36% market penetration and with 75% of the area physicians participating. Experts estimate that in five years "just a few HMOs will dominate a 50% market share."

Nationally, HMO enrollment in 1984 increased 22.5% and physicians with HMO affiliations now total 20%. Hospitals face the dilemma of operating profitably at 50% occupancy or less.

ATIONAL CONFERENCE ON AGING

The conference is being planned as a forum for discussing the challenges that will arise as the nation tries to provide financing and delivery of health care to the country's increasing elderly population. The AMA in conjunction with the American Nurses' Association, American Hospital Association and American Association of Retired Persons is coordinating the program which will address the following major areas: (1) finance the growing demand for acute and long term care services; (2) strengthen access to appropriate and cost effective services; (3) enhance the quality of care of the elderly in their homes, communities and institutions. The meeting has been scheduled for November 12-13 at the Radisson Mark Plaza Hotel in Alexandria, VA. For info and registration, contact AMA.

ADULT ABUSE

The 1985 Kansas Legislature in adopting SB 72 amended the existing Adult Abuse and Neglect Statute for adults residing in medical facilities (adult care homes, hospitals, state institutions and adult family homes) whereby:

1. A certified psychologist is added to the list of persons required to report incidents of suspected abuse and neglect in adult care homes, medical facilities and adult family homes;

2. A Class B misdemeanor penalty is established for all persons required to report who knowingly fail to make a report or cause a report not to be made.

To report, call your local SRS office.

DUE PROCESS UNDER PRO

Any physician who receives an adverse PRO reconsideration decision should have the right to an administrative hearing and judicial review just as beneficiaries now do under the program, the AMA has informed Congress.

The AMA expressed this belief in a letter to David Durenberger (R-MN), Chairman of the Subcommittee on Health of the Senate Finance Committee. Provision for an administrative hearing and judicial review for physicians is one of 19 amendments to the PRO law that the AMA has recommended. The AMA has proposed that a physician be entitled to an administrative hearing if the amount in controversy is $200 or more and to judicial review if the amount is $2,000 or more. Equity and fairness, the AMA said, should dictate that physicians have the same opportunity for due process under the PRO law as beneficiaries already have.

TO IMPROVE STATE/EPA DECISIONMAKING

Kansas is one of five states selected for a pilot project aimed at improving environmental decisionmaking. The project will seek better ways of applying environmental information to the process of setting priorities and allocating resources. The states are: Kansas, Kentucky, Maryland, New Jersey and Oregon. Each pilot project will be allocated up to $300,000 in FY '85. Kansas' assignment will be to determine how to set priorities to best address environmental troubles statewide by assessing the existing data and determining how cleanup efforts can best be coordinated. The task is expected to take three years. If this exercise doesn't become just another paperchase, Kansas could lead the way for the nation to better handle its environmental problems.

COMMUNICATIONS

Patients who take a more active role in communicating with their physicians may cope better with chronic disease on a daily basis, according to a study conducted by researchers at the UCLA Schools of Medicine and Public Health. The study suggests that patients who become more assertive in seeking information from their physicians also have a greater impact on decisions affecting their health and treatment. On the other hand, patients may be intimidated about questioning a particular treatment course, so they often passively accept whatever their physician suggests. Patients who remain relatively uninformed and who do not take an active part in their care may be less prepared to translate treatment programs into workable daily routines to help them manage their illnesses. In busy medical practices, physicians may find it difficult to encourage patient involvement in medical decisions. However, without some encouragement many patients find it difficult to be assertive.

SOCIAL SECURITY CHANGES

Under new provisions of P.L. 93-460, claims of some patients whose disability benefits were terminated will automatically be reviewed; however, the following need to reapply:

- Those who received an initial denial notice from March 1, 1981, through October 9, 1984, and who had no reconsideration or hearing pending on or after October 9, 1984: and

- Those who received a termination notice from March 1, 1981 through October 9, 1984 and no appeal was pending on or after June 7, 1983.

These individuals may file a new application for review under the new rules. Should the claim be allowed, benefits are retroactive for up to 12 months from the date of the new application. For additional information, contact any Social Security office.



Figure 5. Gross findings of the opened tracheal specimen noted a fungating tumor mass, 3 x 4 cm in width from a 2 cm base along the posteriolateral wall.

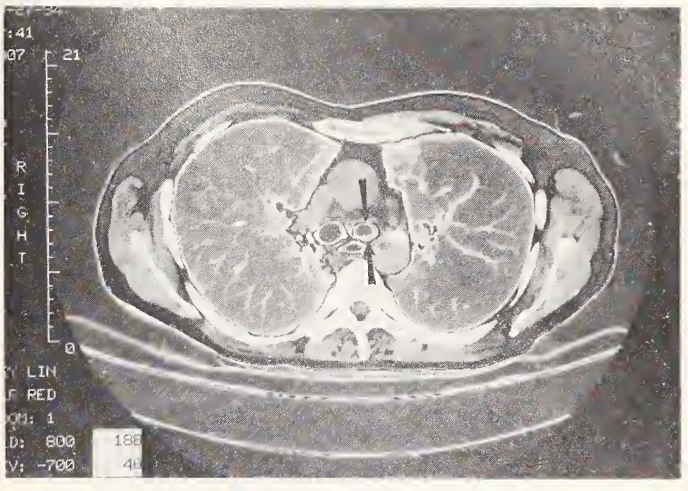


Figure 6. Followup CT scan of the chest and mediastinum noted no adenopathy or residual tumor and only slight deformity of the left main stem bronchus (depicted by arrows).

The patient was seen approximately four weeks after surgery with complaints of persistant cough and shortness of breath. The patient had just completed an outpatient bone scan, which was normal, and was anticipating radiation therapy. Due to the above complaints a therapeutic bronchoscopy was performed prior to beginning radiation therapy. At bronchoscopy granulation and scar tissue were noted at the suture line with resulting mild stenosis of the left main stem bronchus at its origin. Cytologic studies of bronchial washings produced positive results for squamous cell carcinoma. The patient subsequently received 5,222 rads to the resection site, 5,100 rads to the right hilum, and 4,700 rads to the supraclavicular area. Followup bronchoscopy, performed at four and ten months, revealed only slight stenosis of the left main stem bronchus but negative bronchial washing cytology. At 18 months, the patient was asymptomatic and a CT scan of the chest and mediastinum noted no adenopathy or lesion with only slight deformity of the left main stem bronchus (*Figure 6*).

Discussion

As early as 1767, a fibroma of the trachea was described by Lieutaud as an incidental autopsy finding. Langhans was the first to report a case of primary carcinoma confirmed by histologic study in 1871.[1] With the development of the bronchoscope, reports of tracheal tumors have become progressively more frequent.

Incidence

Primary carcinoma of the trachea is still a rare entity, and only a few institutions have acquired significant experience.[2, 3, 5, 6] Culp reviewed a series of 89,600 autopsies and discovered only four cases of primary tracheal carcinoma.[1] Houston documented only 110 cases during a 20-year period at the Massachusetts General Hospital.[3]

Symptoms and Clinical Course

The ages of patients reported with primary carcinoma of the trachea range from 20 to 69 years, with an average age of 57 years.[2] Males have only a slightly higher incidence than females.[2]

Tracheal carcinoma is more commonly associated with a history of heavy smoking.[7, 8] A vigorous cough reflex, effective ciliary action, and large diameter of the trachea that prevent retention of irritants and mucous may explain the rarity of tracheal carcinoma in comparison with carcinoma of the larynx, lung, and bronchus.[9, 10]

The silent nature of the tumor can delay diagnosis an average of 15 months from onset of symptoms.[2, 10, 11] Often the diagnosis is delayed due to the presence of nonspecific symptoms frequently attributed to more common diseases such as chronic bronchitis, asthma, or heart failure.[2, 8, 10, 12] The most common complaint is that of a persistent cough. If dyspnea is the complaint, it is frequently paroxysmal in nature and occurs most often at night when the patient is recumbent.[2]

The large diameter of the trachea allows for reduction of the lumen by as much as 80% of its normal caliber before symptoms appear. Symptoms, therefore, are due to mechanical disturbance and depend on size and location of the tumor, protrusion of tumor from the tracheal wall, and width of the trachea.[2, 8]

Radiologic Findings

Seventy-five per cent of patients with a tracheal carcinoma will have a normal posterior anterior and lateral chest x-ray.[2] Overpenetrated films or oblique views are useful in highlighting tracheal tumors while expiratory films may demonstrate characteristic air trapping.[2, 12] Lung and mediastinal tomograms are most helpful in demonstrating tumor size and extraluminal extension. These are positive 81% of the time when a standard CXR is negative.[2, 7] CT scan of the chest is the most accurate diagnostic procedure and can clearly reveal narrowing of the tracheal lumen by an intrinsic mass.[13] CT scans can analyze tissue morphology and type, allowing visualization and relationships of the tumor to associated mediastinal structures.[13] Grillo suggests the use of barium esophagram to outline the extent of projection of the tumor into or against the esophagus.[4]

Diagnosis of tracheal carcinoma should be suspected on the basis of the patient's history and the clinical and radiographic findings. Routine blood and urine studies are usually not helpful.[2] Cytologic examination of sputum has been found to be accurate in 75% of cases if the tumor is of epithelial origin. Cytology is not helpful if the tumor is of mucous gland or mesenchymal origin.[2]

Diagnostic Procedures

Bronchoscopy is an important diagnostic procedure and should be performed in patients unresponsive to medical management of adult wheezing or stridor.[2, 8, 9, 11, 12] Bronchoscopy allows for accurate definition of the site of tumor, growth, and its relationship to associated structures of the bronchial tree, as well as access for biopsy and tissue diagnosis.[2, 8, 9]

Pathological Features

Grossly, most tracheal carcinomas are ulcerative, exophytic, infiltrative, and may partially obstruct the tracheal lumen, as in our case.[2] About half the lesions arise from a tracheal segment and are 2.5 cm or less in diameter. The lower third is the most frequent site (44%), followed by the upper third (33%), and middle third (23%). A vast majority (about 60%) of tracheal tumors arise from the posteriolateral walls of the trachea.[1]

Tracheal tumors originate from three cell lines: tracheal epithelial cells, mucous glands, or mesenchymal cells.[2] Most tracheal carcinomas are classified as squamous cell or adenoid cystic carcinoma[1, 2] (cylindroma). A variety of other rarer tumors can occur, including carcinoid adenoma of the trachea, carcinosarcoma, pseudosarcoma, mucoepidermoid carcinoma, squamous papilloma, fibroma hemangioma, chondroma, and chondrosarcoma.[14] Squamous cell carcinoma, in most series, is the most common primary lesion of the trachea.[1-4, 10]

It is felt that spread of squamous cell carcinoma of the trachea is first to paratracheal lymph nodes; it then involves mediastinal structures via direct extension. Adenoid cystic carcinoma, although characteristically slow growing, may invade submucosally for longer distances of the trachea than are grossly evident. Its spread, however, tends to displace mediastinal structures rather than to invade them directly.[14] It has been shown that both types are capable of significant local invasion with destruction of tracheal cartilage, involvement of nodes, lung, great vessels, or esophagus.[2]

Operative Approach

The operative approach to tumors of the trachea has been well described.[3, 15] In general an anterior route, beginning with a collar incision and adding an upper mediansternotomy if needed, is used for lesions of the upper or mid trachea. For tumors of the lower third and carina, where meticulous dissection may be needed, a right posterolateral thoracotomy is the best approach.[15] In our case, we chose the latter using a right posterolateral thoracotomy via the fourth interspace. Our resection was completed removing approximately 4 cm of the lower trachea just above the carina. Primary reconstruction was facilitated by mobilization of the trachea, right hilum of the lung, and through cervical flexion. The anastomosis was completed with the use of interrupted simple sutures of 3-0 Ethibond. Technical improvements such as cervical flexion, laryngeal release, and hilar mobilization can permit resection of as much as 50% of the trachea with subsequent primary reconstruction.[4, 14, 15] In most cases, the operation can be performed without the use of cardiopulmonary bypass.[4]

Postoperative Complications

Postoperative complications of tracheal operations include rupture of major vessels, mediastinitis, pulmonary insufficiency, chyle leak, lung herniation, and necrosis of skin flaps or tracheal wall. We encountered the formation of stenosis of the left main bronchus possibly due to operative technique rather than a recurrence of the tumor at the anastomotic site.

(Continued on page 278)

PRESIDENT'S MESSAGE

I do believe the world is going mad! At least part of it, some of the time. I have recently been reading of some of the suits and awards that have occurred and cannot believe what is happening. Our jury system is based on the idea that if you go to court, you will be judged by a jury of your peers. When I think of peers, I think of my neighbor, a friend, a business-person downtown, people who worry about paying their bills, inflation, recessions, helping people, shopping for the best bargains, and raising their children to be honest and worthwhile citizens. In short, a "good" person.

Yet when that very same person is selected for jury duty, all semblance of reason seems to disappear. In a recent trial reported in the papers, a company was sued because its foreman called one of the subcontractors and threatened to send the sheriff out because the subcontractor had written bad checks. The subcontractor and his wife sued for "severe mental distress." At the trial, both parties agreed that the language used on the phone was not vulgar, not obscene, did not threaten life or limb. The case went to court and the plaintiffs were awarded $350,000! This case was appealed to the Kansas Supreme Court who properly threw it out, as it should have been in the first place. But a question came to mind, suppose the phone call had been abusive, suppose the caller did use profanity, suppose he did threaten bodily harm, THREE HUNDRED FIFTY THOUSAND DOLLARS?

Another even more imaginative case is still in the news. An Oregon judge declared a mistrial against the Church of Scientology. One of the church members had signed up for some self-improvement courses that cost her $3,200 and then was disappointed when they did not produce the results that she hoped for. She finally withdrew from the church and sued for "secular fraud," and she was awarded — get this — $39 million. The judge who heard the case just recently declared a mistrial deciding that that was not an appropriate award, which has to be a top contender for the understatement of the year. The amazing thing is, that this was the second trial, and she was actually awarded $2 million in the first trial.



All of this is simply to point out that our jury system has been converted to a lottery system, whereby if you hit "a lucky number" you are set for life. It illustrates, also, that there has to be a limit on awards to restore some semblance of sanity to the tort system. The legislative objectives of the Kansas Medical Society this year are to enact legislation that will establish reasonable limits on awards, mandatory screening panels, and limitations on excessive contingency fees.

The officers of the Kansas Medical Society, the Executive Director, and the various committees involved cannot do this on their own. You must become active, explain the problems to your patients, and talk to various civic groups. If you are not willing to do this, it will not be accomplished. If you need any information, help, suggestions or ideas, contact the Medical Society office or me.

L. Leonard, M.D.

President

EDITORIAL COMMENT

Process of Accommodation

Medical practice, long considered their private property by physicians and patients, has increasingly entered the public domain. This is borne out by the matter of medical malpractice which, perhaps more than any, has pervaded all strata of the profession as it brings broad public attention. It may be part of the current public fascination with the idea of suing *someone* for *something*, but medical malpractice has a character all its own just as does medical practice among other services.

It has been examined and reexamined by both profession and laity, but only recently has one aspect of malpractice received anything like analytic attention: the effect of a suit on the functioning and reactions of the physician when confronted with a subsequent suit. Although relatively infrequent in the past, the matter is now being studied by psychiatrist Sara C. Charles of Chicago whose qualifications include having been the defendant in a suit herself. It obviously is difficult to translate anything so severely personal as such an experience (whether won or lost) into the classical terms of scientific approach — firm objectivity and reproducibility, for example. Personality, local factors, extenuating circumstances, financial concerns would obviously influence individual reaction to the event, whether initial or subsequent, justified or not, and condition the stress of the experience.

One feature of interest has emerged, however: subsequent exposure to litigation prompts physicians to accept the matter with more equanimity and this is attributed not so much to the development of emotional calluses as to the individual's willingness to be more open with family and friends. Perhaps it is the realization that one really can survive the grim reality, that the professional image is not so greatly damaged as feared initially (itself a by-product of the increased frequency), and that there is a great deal of support available from family, colleagues, even other patients. There may be some blunting of emotions by the feeling that there is a limit to what a person can tolerate beyond which one must accept the protection of substituting a degree of objectivity (detachment?). The implication at this point is that by instilling this preparatory attitude at some point before the event, the individual will be better able to cope with this situation which has moved from anathematic almost to a way of life in a startlingly short time.

Whatever the anatomy of the matter, it leads to speculation as to the way in which the character of medical service and its practitioners will be changed in the process. New developments create pressure on the young who will fill the future ranks as well as the active profession. Changing methods, attitudes, and goals challenge the traditional concept that medicine has an inherent stability in unalterable dedication to ancient and honorable principles. Even now, more than one medical voice has been heard counseling prospective medical students to turn to other pursuits.

Still, those contemplating medical careers cannot be ignorant of the prevailing conditions. Moreover, they will come to intellectual, emotional, and professional maturity in a far different world than their predecessors and may be spared their elders' feeling that the world they have known is collapsing around them. To all indications, they are motivated by as high ideals of service as prompted those before them, and, as is characteristic of each medical generation, they are sure that they will do a better job of it — as, in fact, they probably shall (even as, it is hoped, they gain added appreciation of what the old ones went through).

The malpractice problem will not go away. At the moment, efforts to develop a supportable financial structure dominate the public and professional attention. Personal effects have been met at the personal level. Whether a collective medical accommodation can be developed is at least problematic. Generations of patients move along at the same rate as generations of physicians, and the accommodations of today are altered tomorrow. If public and profession find unchanging happiness together, *that* will be a change. — *D.E.G.*

SPECIAL FEATURE

Picking a Money Manager

M. DONALD McFARLAND, JR.,* *Kansas City, Missouri*

PROFESSIONAL money managers perform a variety of investment-related functions. There are money managers who specialize in multi-million dollar retirement plans as well as those who handle $100,000 plans. Many individuals rely on these managers to keep their personal wealth intact.

Companies, individuals, and groups now turn more frequently to professional money managers because they have neither the time nor the expertise to manage their investments themselves. Heavy daily job responsibilities, intricate investment decisions, and voluminous paperwork have motivated many executives to seek professional money management.

Currently it is estimated that these money managers control approximately $1.5 trillion in assets. The universe they manage includes corporate pension and profit-sharing plans; professional corporations, such as those set up by physicians and architects; wealthy individuals; labor unions; state retirement plans; religious groups; and other not-for-profit organizations.

How does the investor find the right money manager to help with a particular plan? The first thing to understand is that professional money managers vary tremendously in both investment management style and the monetary scope of accounts they will accept to manage. With approximately 8,000 money managers nationwide, selection of the right one is no easy task. In fact, the choice can be just as difficult as selection of the right stock. The second point to remember is that bigger is not necessarily better. Managers who handle fewer and smaller accounts can sometimes respond to rapidly changing market conditions faster than managers of larger accounts.

Many companies have been content to accept low performance — *i.e.*, 7-8% annual returns — simply because they lack time to make a change, they don't know how, or they are unaware that there are managers who have documented performance levels in excess of 20% average annual returns spanning several years.

The following guidelines may help an investor who is ready to consider professional management.

The DON'Ts

- **DON'T** hire a money manager until you have specifically defined your investment objectives. It is imperative that you choose a manager who understands, respects, and consents to your level of risk tolerance. An agreement in writing should prevent unpleasant surprises.
- **DON'T** select a money manager out of convenience. Everyone has a tendency to take the course of least resistance. Too often an investor may select his/her banker, broker, insurance company, or someone recommended by a friend. Remember that your friend's definition of risk tolerance may be totally different from yours.
- **DON'T** evaluate performance of a prospective manager based on one good or bad year. Look at a minimum of five or — preferably —ten years. Successful managers are those who have achieved average returns of 15-20% per year for the past ten years. An investor who receives substandard performance may wish to shop for another manager.
- **DON'T** hire a manager who has so many accounts that yours will lack personal attention. Some managers will accept accounts as small as $50,000; others $10 million. The size of your account relative to total assets under management is a key factor in determining which manager will be receptive to your account. In other words, your $50,000 account is insignificant to a billion-dollar money manager, but perhaps more suitable and welcome to a $5 million manager.
- **DON'T** make your decision based on the lowest fees. Fees are just one of several important factors to review. Others include: Is there mutual respect between you and the manager? Will your risk tolerance level be respected? Is portfolio perform-

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ance reporting accurate and on time? Learn the answers to your questions by asking for names of other clients and call them. A normal yearly charge is approximately 1-3% of total assets under management depending on the size of the account. These fees are usually tax-deductible for retirement plans.

The DOs

- **Do** take time to shop around. Hire a manager only after reviewing top performers from across the United States, not just those in your area. If your plan is large (in excess of several million dollars), you should evaluate several managers. Most managers who are seeking additional accounts will come to you with a formal presentation.
- **Do** continue to monitor and compare your manager's performance to others after she or he has been hired. Consultants and major brokerage firms offer this important comparison service for a nominal fee. Some track as many as 400 managers and can compare your manager to others based on performance.
- **Do** be sure you understand all fees. Know the difference between "hard" dollars (set fees for various services) and "soft" dollars (brokerage commissions).
- **Do** strongly consider selecting more than one manager, particularly if your plan is sizable, *i.e.*, in excess of several million dollars.

Investment philosophies of money managers vary widely. However, most managers follow one of three basic philosophies. The first group — the fundamentalists — look at the large picture. They take the economy and divide it into approximately ten sectors and determine which ones are doing well during a particular market cycle. They then select promising industries within a particular sector, and pick specific stocks within those industries.

A second popular investment philosophy is the school of technical analysis. This type of money manager isolates specific companies that appear to be good "buy" or "sell" candidates by analyzing charts and graphs of historical price movements in particular stocks.

And finally, there are the market timers who rotate in and out of the market based on what they think is going to happen during a particular cycle. All of these managers use their expertise to determine how much of a portfolio's assets should go into stocks versus cash and debt issues.

An important factor in your choice of a money manager is determination of who actually makes the major investment decisions. Is it one individual or a committee? You need to be advised if the money management firm's key decision-makers leave the company, or if there is high turnover in key areas of the firm.

Locating the right money manager is no easy task. The process is referred to as a "search," and can be quite involved, depending on the scope of the task at hand. Firms that provide these specialized services by acting as third-party consultants may monitor up to 400 top money managers nationwide and narrow this list to 40 or 50 whom they recommend. These money managers vary from conservative to aggressive. Your previously defined risk tolerance levels will help to determine the right one for you.

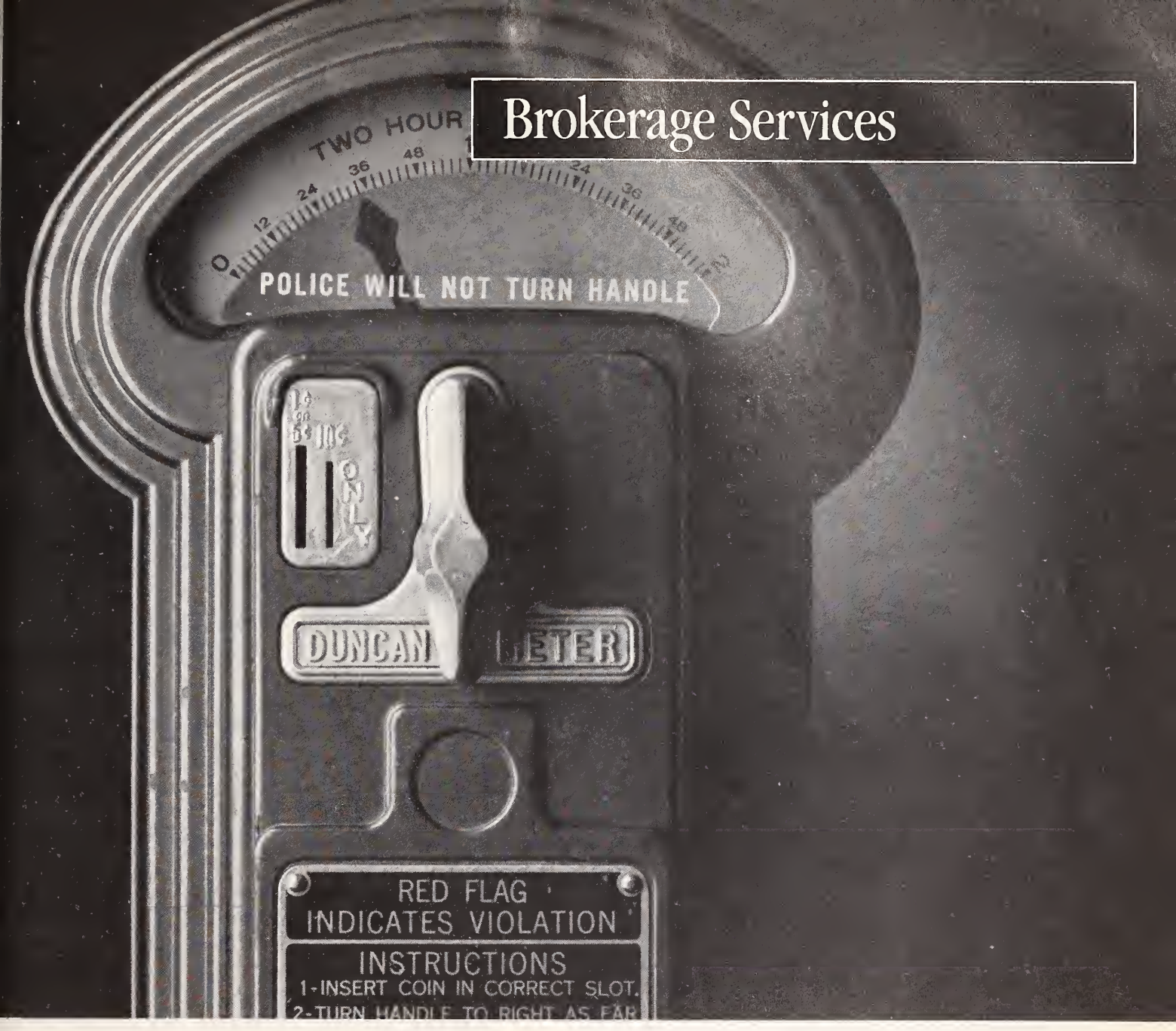
In addition to conducting searches, these investment management consulting firms also continously track managers by analyzing such factors as stability, reputation, continuity of management, consistency of performance, flexibility, and reporting.

In summary, it makes sense to go to the experts for help in selection of the right money manager. Whether your investment is $50,000 or several million dollars, professional money managers should be considered. Thanks to expert help in the selection process, you may find reasonably prices money managers with solid track records.

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PTCA

(Continued from page 266)

difficult and sometimes impossible. Dilatation in a patient with multivessel disease does not imply that all stenotic lesions were successfully treated. There has been no difference in the occurrence of emergency operations or mortality after PTCA in a single or multivessel disease.[7] It is very likely that with growing experience and refinement of technique, multivessel dilatations will constitute a larger proportion of angioplasty procedures.

PTCA may be a valuable alternative to reoperation in selected patients with previous bypass surgery.[8] Suitable candidates might include those who have stenosis of the distal anastomosis and certain patients with progression of disease in the native circulation, either distal to the anastomosis or in a previously non-bypassed vessel. Dilatation of aortic graft anastomosis lesions and proximal graft lesions appear to be associated with a higher rate of restenosis, but these lesions can still be successfully dilated.

PTCA may play a valuable role during acute evolving myocardial infarction. PTCA may be used when thrombolytic therapy fails to restore blood flow or has left a major residual stenosis. PTCA restores blood supply immediately and may be the only intervention needed.[9]

Cost Effectiveness

The cost of PTCA in the short run appears to be less than that associated with bypass surgery. However, this difference may decrease if restenosis occurs and repeat diagnostic and therapeutic procedures are needed. The long-term costs in some cases may be higher than bypass surgery without preceeding PTCAs. Early and more consistent return to work is seen after PTCA and this fact favorably influences the indirect costs attributable to the management of patients with coronary artery disease. Seventy-nine per cent of patients who undergo angioplasty return to work in an average of three weeks. By comparison, 69% of the patients who have bypass surgery do not return to work for an average 11 weeks.[10] It is estimated that 15-20% of patients who require revascularization can be treated with angioplasty. The functional outcomes are comparable. Pain and suffering are considerably less with angioplasty compared to bypass surgery. Thus there can be significant economical and functional advantages with angioplasty.

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Summary

PTCA is a palliative measure to reduce the degree of coronary artery stenosis and increase myocardial perfusion. This goal can be achieved in up to 80-90% of patients selected for the procedure. The availability of an alternative form of therapy, less invasive than thoracotomy, is appealing and in successful cases may at least delay coronary artery bypass surgery. Proximal single vessel disease still represents the ideal indication for PTCA. With growing skill and refinement of the technique, the procedure has been expanded to other subsets of patients. Technical improvements will continue to improve the success rate and further decrease the complications of this procedure. It is hoped that the increasing usage of the procedure does not result in the application of the procedure to non-critical lesions. Economic benefits of PTCA relative to surgery are encouraging.

References

1. Gruentzig AR *et al:* Non-operative dilatation of coronary artery stenosis. *N Engl J Med* 301:61-68, 1979.
2. Gruentzig AR, Hollman J: Improved primary success rate in coronary angioplasty using a steerable guide wire system. *Circulation* 66:11-330, 1982.
3. Holmes DR Jr *et al:* Angiographic changes produces by percutaneous coronary angioplasty. *Am J Cardiol* 51:676-683, 1983.
4. Hall D, Gruentzig AR: Percutaneous transluminal coronary angioplasty — Current procedure and future direction. *Am J Roentgenol Radium Ther Nucl Med* 142:13-16, 1984.
5. Kent KM *et al:* Improved myocardial function during exercise after successful percutaneous transluminal coronary angioplasty. *N Engl J Med* 306:441-446, 1982.
6. Dorros G *et al:* Percutaneous transluminal angioplasty: Report of complications from the National Heart, Lung and Blood Institute PTCA Registry. *Circulation* 67:723-730, 1983.
7. Vliestra RE *et al:* Balloon angioplasty in multivessel coronary artery disease. *Mayo Clin Proc* 58:563-567, 1983.
8. Douglas JS *et al:* Percutaneous transluminal coronary angioplasty in patients with prior coronary bypass surgery. *J Am Coll Cardiol* 2:745-754, 1983.
9. Hartzler GO *et al:* Coronary angioplasty for acute myocardial infarction: An updated experience. *Circulation* 68:111-141, 1983.
10. Jang GC *et al:* Comparative cost analysis of coronary angioplasty and coronary bypass surgery: Results from a national cooperative study. *Circulation* 66:11-123, 1982.

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Tracheal Carcinoma

(Continued from page 270)

Treatment and Prognosis

In the past 20 years, a great deal of information has been gained on tracheal pathologies such congenital stenosis, trauma, inflammatory injuries, or iatrogenic lesions.[15] This has brought about improved surgical techniques and a decrease in mortality.[15] The surgical technique used should be determined by size, site, and histologic appearance of the tumor.[8]

Grillo suggests that benign tumors of the trachea are nearly always resectable with primary reconstruction. Squamous cell carcinomas and adenoid cystic carcinoma should be removed if primary reconstruction can be performed, followed by postoperative irradiation if resection margins are involved.[4]

Tumor location, extension, and infiltration into adjacent structures ultimately affect resectability and thus can influence prognosis. However, improved surgical techniques and anesthesia have provided for a decrease in the morbidity and mortality rates.[3, 4]

Due to the above findings, aggressive surgical management and postoperative radiation are strongly advocated if tumor resection margins are involved or local invasion is present. As first reported by Grillo, prolonged survival supports the aggressive surgical approach when possible, with the use of radiation therapy postoperatively for treatment of residual tumor or to aid in controlling local recurrence.[4] We concur with the above management of primary carcinoma of the trachea.

Summary

Primary carcinoma of the trachea is a rare tumor. The nonspecific symptoms are due to mechanical disturbances of the lumen and are frequently attributed to more common disorders such as asthma, chronic bronchitis, and heart failure. Diagnosis is best supported by adequate history, physical examination, and a high index of suspicion. Tomograms and CT scan of the chest, along with bronchoscopy, can be used for assessment of a primary tumor and its mediastinal involvement. As utilized in this case, we believe aggressive surgical management should be elected when possible with subsequent use of radiation therapy for treatment of residual tumor and prevention of recurrence.

References are available on request from Dr. Tatpati, UKSM-Wichita, 1010 No. Kansas, Wichita KS 67214.

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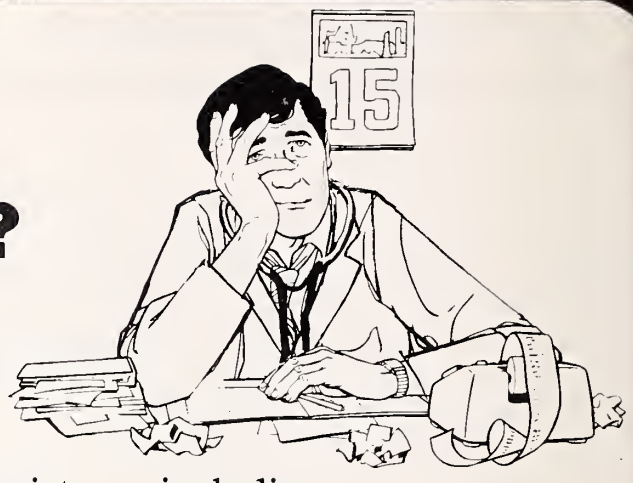
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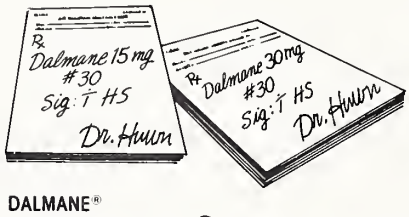
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References: **1.** Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al:* Sympasium on the Treatment of Sleep Disorders, Telecanference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



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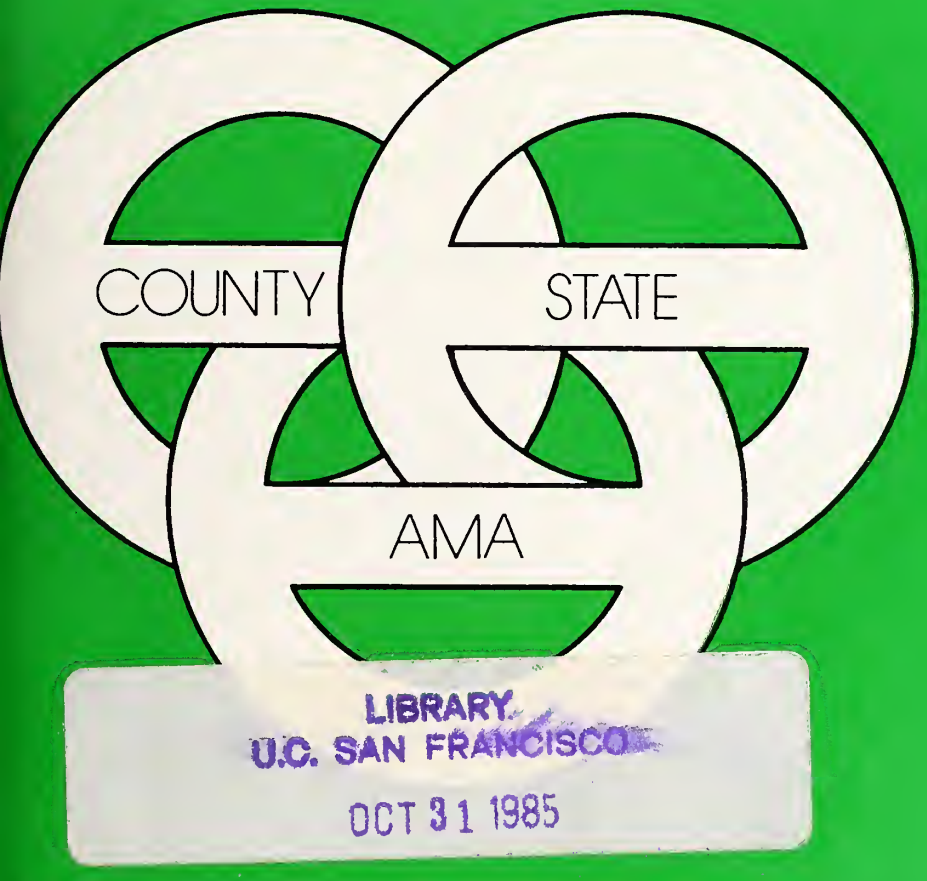
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KANSAS MEDICINE

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On May 5, 1985, the Kansas Medical Society House of Delegates voted to adopt the requirement of unified membership with the American Medical Association. This issue of KANSAS MEDICINE is devoted to that subject.

UNIFIED MEMBERSHIP

KMS Newsletter 296a

THE JOURNAL OF THE KANSAS MEDICAL SOCIETY

KANSAS MEDICINE

• The Journal Of The Kansas Medical Society •

Volume 86, Number 10, October 1985

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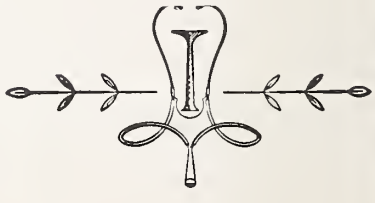
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Dear Colleague:

Recently you and your fellow Kansas Medical Society members achieved a milestone--one that gives you the strongest possible representation and influence within organized medicine. As you may know, the Kansas Medical Society has adopted a policy of unified membership with the AMA by an overwhelming majority vote of the KMS House of Delegates.

You have made a commitment to unity in the medical profession, and on behalf of the AMA, I would like to thank you for that commitment.

The decision to unify was sound. The policies made in Washington, D.C. have as much impact on you and your patients as those made in your state capitol, and membership in your local, state and national societies is the best mechanism to influence those decisions.

Also, by supporting all levels of organized medicine, you will have an even stronger voice in AMA policy. AMA policy begins with resolutions originating at the county medical societies. These resolutions are considered by the KMS House of Delegates. If adopted, they are carried to the AMA by the delegates from Kansas. You will have an opportunity to participate in this policy-making process. You can make a resolution at your county medical society or at the Kansas Medical Society which may eventually become the policy of the AMA.

I would also like to reiterate just two of the many tangible benefits of unification: All Kansas AMA members will receive a 10% rebate on AMA dues because of your unified status; also, the AMA has frozen 1986 dues for Kansas (other dues were increased by $45 for regular AMA members who are not members of newly unified societies).

Again, thank you for your desire to make your views a part of local, state and national policy. Your continued support of your county society, KMS and the AMA will keep our profession strong and give us the resources to carry out the urgent tasks that need to be accomplished.

Sincerely,

W. S. Hotchkiss

William S. Hotchkiss, M.D.

WSH/dm

Healthy Lifestyles

Americans are getting stronger. They are more interested in eating better, exercising more, and providing a cleaner, safer environment for themselves and their children. They need and want information that will help them live longer, healthier lives.

The American Medical Association is meeting that need. In fact, the AMA is convinced that one answer to cutting the costs of medical treatment is prevention: heading off many of the problems that will ultimately require medical care. But cost is not the only concern; this type of public effort is at the heart of the AMA's commitment to "promoting the art and science of medicine, and the betterment of the public health."

Targeting the Killer

The AMA is working on many fronts to help Americans develop healthier lifestyles. One of its major thrusts is to eliminate smoking, which the U. S. surgeon general has labeled "the number one preventable cause of death." Smoking contributes to more than 340,000 premature deaths a year, including 30% of all cancer deaths. It is behind millions of debilitating chronic diseases; it causes cancer of the lung, throat, mouth, esophagus, pancreas, and bladder.

The AMA is committed to working with the profession, the government, and educators to make society "smoke free" by the year 2000. Some of the measures already adopted by the House of Delegates include having the AMA:

- Urge Congress to strengthen warnings on cigarette packages to include messages that smoking causes cancer of the mouth, larynx, and lung; is a major cause of heart disease and emphysema; is addictive; and may result in death;
- Ask the U. S. surgeon general to place health hazard warnings on snuff and chewing tobacco packages, and to study the safety and efficacy of nicotine chewing gum as an aid to smoking cessation;
- Encourage physicians to establish a policy to publicize the hazards of smoking, and to schedule extra time to explain the health risks of smoking to their patients.

A National Nightmare

The AMA is also addressing the problems of alcohol — the number one drug of abuse in our society. Alcohol abuse adversely affects all body systems. It has been linked to hepatic cirrhosis and to cancers of the upper alimentary and respiratory tracts.

This insidious killer is also implicated in nearly every type of traumatic death studied. In one city, a recent study showed that 51% of homicide victims were legally intoxicated; 70% had positive blood alcohol concentrations. Of the 48,609 deaths that occurred on the nation's streets and highways in 1981, 20,658 (43%) were known to involve alcohol.

Alcohol's damage can be measured in monetary terms as well. It is estimated that in 1983 the total cost to society for alcohol-related treatment, lost life and productivity, property loss, crime, and welfare was $116.7 billion.

The AMA is taking strong steps to fight alcoholism. Its *Manual on Alcoholism* and the *Manual on Drug Abuse* provide physicians with valuable information on treating alcoholism and other addictive disorders. The Association has sponsored conferences on impaired physicians to alert the profession to the problem within its own ranks. The AMA has established a standing Panel on Alcoholism within the AMA Council on Scientific Affairs, which in 1982 adopted a report and recommendation on fetal alcohol syndrome. The AMA also supports state and federal legislative efforts to strengthen drunk driving laws and their enforcement.

A Multi-Faceted Effort

The AMA is working on other fronts as well. The AMA provides information to the public and the profession on the importance of nutrition. One of the most critical aspects of this program is fighting the misinformation and "pseudo-science" attached to nutritional needs.

The AMA is also pursuing greater automobile safety. The AMA House of Delegates supports mandatory seat-belt use, mandatory child-passenger restraint laws, immediate implementation of a mandatory air bag program, and legislation to promote the availability of seat belts in school buses and in all motor vehicles carrying passengers.

Moreover, the AMA is committed to supporting efforts aimed at the prevention of childhood diseases through immunizations, safeguarding the environment and decreasing pollution, examining occupational health problems, and looking at the health

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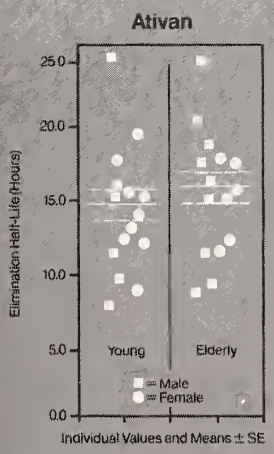
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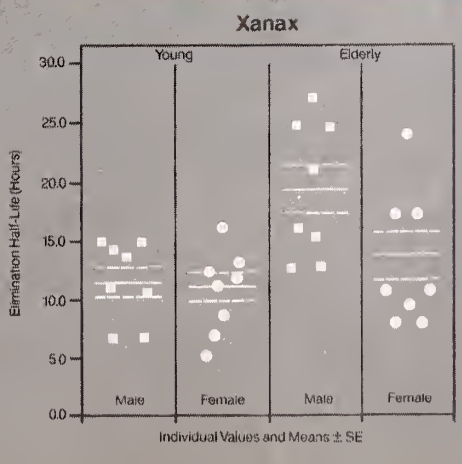
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References:
1. Greenblatt DJ: Clinical study, pharmacokinetics and bioavailability in the elderly, Ativan® (lorazepam). Data on file, Wyeth Laboratories.
2. Greenblatt DJ, Allen MD, Locniskar A, et al: Lorazepam kinetics in the elderly. Clin Pharmacol Ther 26:103, 1979.
3. Greenblatt DJ, Divoll M, Abernethy DR, et al Alprazolam kinetics in the elderly. Arch Gen Psychiatry 40:287, 1983.

Wyeth Laboratories
Philadelphia, PA 19101

See important information on preceding page.

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Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (IV) for (lorazepam) Anxiety

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

HOW SUPPLIED: 0.5, 1.0 and 2.0mg tablets.

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Healthy Lifestyles

(Continued from page 282)

risks of energy generation, among many other concerns.

Physicians who want to involve themselves personally in this battle have the perfect avenue — they can join the AMA. Only the AMA has the unity, strength, and leadership to promote wellness on a national scale. Membership in the AMA gives you a voice in making decisions that affect the public welfare. If you have a commitment to the future health of this nation, join the AMA.

VOX DOX

To the Editor:

A recent letter in the Letters to the Editor section of TIME Magazine from a reader in Oslo, Norway, has a bearing on KMS Resolution 85-17 (Medical School Class Size). The writer suggests that the United States should change immigration laws "so as to deny permanent residence to all professionals coming from Third World countries" to prevent a brain drain from those nations.

If underserved areas of physician need are rapidly declining in the United States, Kansas may soon face a "physician glut." The idea proposed by the writer would not only prevent a brain drain from the Third World, but might also insure that available practice locations in Kansas could be staffed with American physicians.

Dan S. Fairman, M.D.
(Former Kansas Resident Physician)
P.O. Box 745
Glenn's Ferry ID 83623

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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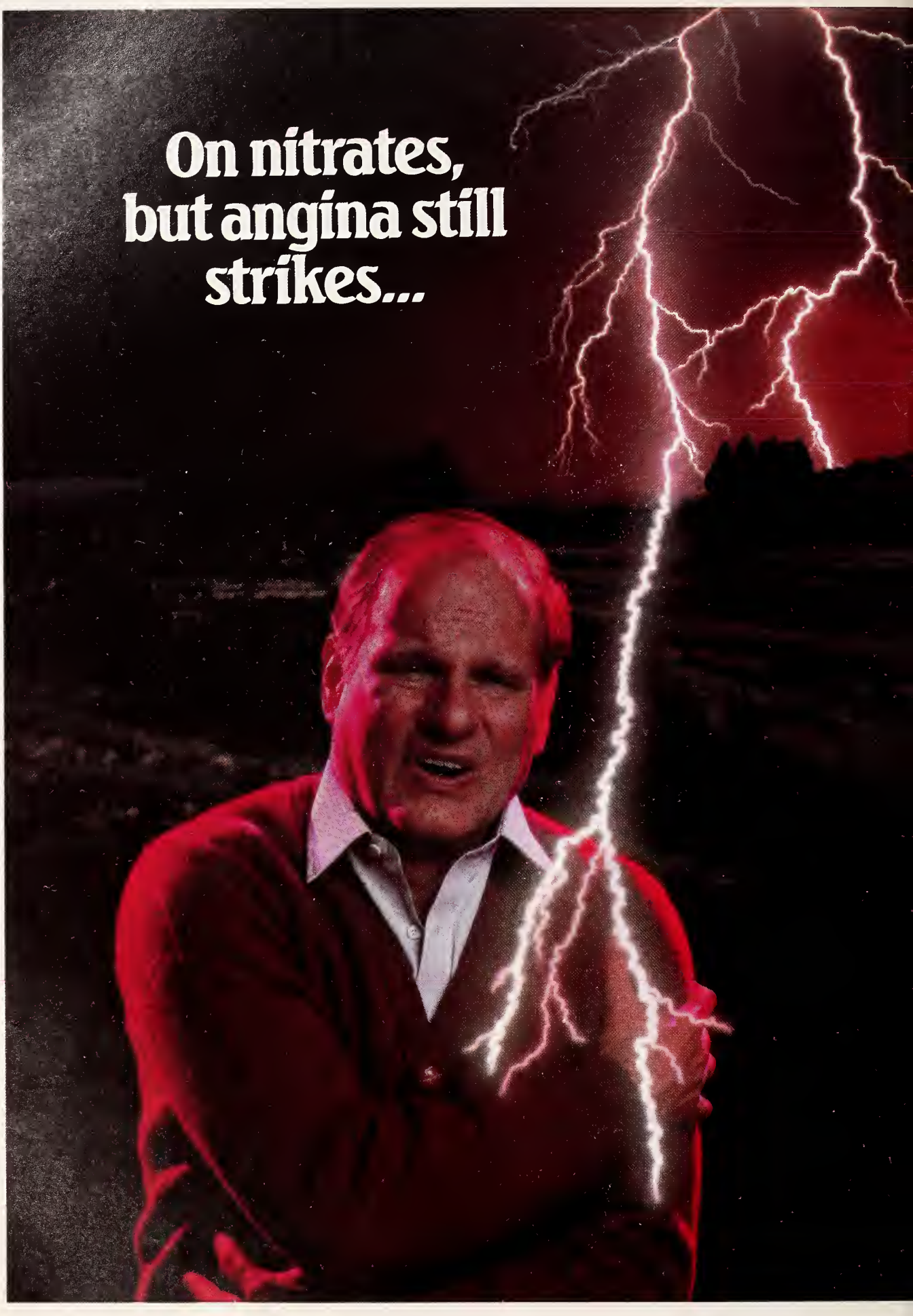


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After a nitrate, add ISOPTIN®
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First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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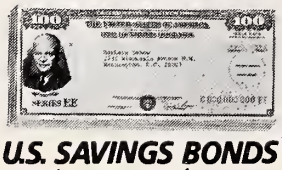


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AMA House of Delegates

Summary of Actions Taken at the 1985 Annual Meeting, Chicago

The AMA House of Delegates met June 16-20 with 371 delegates seated. Representing state medical associations were 296 delegates; 66 delegates represented national medical specialty societies; and nine section and service delegates represented medical students, medical schools, resident physicians, hospital medical staffs, Army, Navy, Air Force, USPHS, and the Veterans Administration. The American Academy of Otolaryngic Allergy was granted a voting seat in the House at this meeting.

In his address, President Joseph F. Boyle, M.D., cited opportunities for the profession to renew its accountability for standards and practice, to recognize and uphold its responsibilities, and to restore the public's confidence in medicine. These include the elimination of inappropriate utilization and excessive charges where these exist and the exercise of increased professional discipline through effective risk management and peer review. The House commended Dr. Boyle for his dedication to the goal of reawakening our professional pride and for his fervent commitment to restoration of the public's confidence in a profession that cares.

Some of the major issues considered at the AMA Annual Meeting were the following:

AMA Finances

The issue of AMA finances and the need for additional dues revenue was a prime issue before the House.

The American Medical Association stands alone as the only organization that represents all physicians nationwide — an advocate for the profession and for patients — to ensure that the quality of care and access to care are not diminished. Yet in its mission the AMA requires resources to match the demands placed upon it by its membership.

The medical profession faces greater challenges today than ever before. In the face of those challenges, America's physicians require — and deserve — a strong national medical organization. We need a strong AMA for effective representation in Washington; to provide aggressive legal representation; to improve the public's understanding of how changes in the medical care system will affect them today and in the future; and to find solutions to the professional liability crisis that is nation-wide.

Mindful of the financial constraints physicians face in today's competitive medical environment, the House concluded that a $45 dues increase — just 12¢ per day — is absolutely essential to ensure the continued strength of the AMA and the future of the medical profession. Kansas and Louisiana, the newly unified states, will be exempted from this increase in 1986.

The AMA is actively investigating new initiatives that will address physicians' heightened concerns about the future of American medicine. In response to some of those concerns expressed by the membership, the Association is examining ways in which the AMA can provide leadership and direction to retain for physicians the role of principal manager of patient care; to help physicians provide quality care as efficiently as possible; and to facilitate creative approaches and other cooperative efforts that will ensure provision of quality patient care and the economic viability of physician-initiated enterprises. These new initiatives are aimed at helping physicians adapt to a changing medical practice environment. Only through the AMA can medicine continue to be a strong, united profession that will sustain the rights of physicians and patients in a turbulent medical environment. Your continued support is crucial if the AMA is to remain strong. Strength is not without costs. But for about a dollar a day, you can help sustain the strength of the AMA at a time when a strong AMA is needed more than ever.

Professional Liability

As anticipated, the problems associated with professional liability occupied much of the delegates' attention. The House considered two reports on the subject. One from the AMA's Committee on Professional Liability reported on special problems plaguing obstetricians and gynecologists and physicians practicing in Florida. Another report was prepared by the Association's Special Task Force on Professional Liability and Insurance. It outlined the many activities undertaken to implement an Action Plan in four areas: (1) education and community action; (2) legislation; (3) defense coordination; and (4) risk control and quality review.

In another action, the House called on the Association to expedite the preparation of an expanded

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and more specific response to the American Trial Lawyers Association's contentions regarding the current situation in professional liability.

Physician Supply

The House considered three resolutions pertaining to the concerns of physicians, the public, and various governmental bodies regarding the issue of physician supply and maldistribution. The House called upon the AMA to recognize these concerns, form a task force to study the problem by evaluating the effects of physician supply and distribution on the quality and costs of medical care and the possible dysfunctioning of the market forces, and, in conjunction with state medical associations, encourage state governments to study their local situations.

Public Awareness

At the 1984 Interim Meeting, the House called for the Association to develop a wide range of activities aimed at informing the public of changes in the medical care delivery system and increasing the public's awareness that physicians are their patients' best advocates in safeguarding the quality of medical care in the United States. At this meeting, the House received a comprehensive report that details specific activities designed to strengthen the Association's longstanding communications activities.

These pilot programs carry a price tag of more than $1 million and include the following: a series of baseline surveys on the public's views toward medicine and physicians in all 50 states; production and evaluation of informational commercials; promotion and distribution of a physician profile film which was viewed by the House at the opening session; public health campaigns in conjunction with local and state associations; and the establishment of an annual national communications workshop.

Joint Ventures

The Board of Trustees submitted a report dealing with medical staff involvement in the development of hospital/medical staff joint ventures. The report concludes that, at the present time, it is not possible

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to develop guidelines for physician involvement in these relationships because of the breadth of the concept, the uncertain legal status of certain joint venture activities, and the lack of reliable experience in the area. The House called for continued study of this issue and asked the AMA to compile and widely disseminate an annotated bibliography of the resource documents on joint ventures and similar arrangements.

National Relative Value Scale

The House received a progress report on the AMA's efforts to secure a grant from HCFA to develop a resource cost-based relative value scale for physicians' services. The report pointed out that a relative value scale is not a fee schedule. The AMA will continue its strong opposition to the implementation of any mandatory fee schedule.

Indemnity Payment System

The House voted to reaffirm its support for the validity of the indemnity payment system as one part of a pluralistic approach to payment methods, and called on the Association to strive to implement the indemnity payment system as a preferred policy at the national level as is appropriate and feasible.

Federal DRG Program

The House approved a position statement that expresses the AMA's profound reservations about the overall impact of the Diagnosis-Related Group system on patient well-being and on the capability of hospitals to continue to provide quality care under that system. The statement also encourages and supports the testing of innovative medical reimbursement systems; urges that new systems be appropriately and adequately tested prior to general application; and asks the AMA to continue to monitor the DRG program and offer constructive recommendations to assure the quality of care to patients.

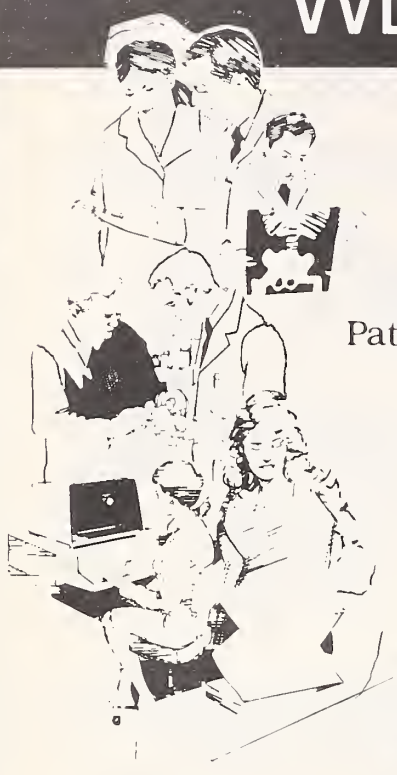
Kansas Delegation

As mentioned above, Kansas physicians will be exempted from the AMA dues increase in 1986. This relief came as a result of adoption of a Kansas-introduced resolution. With the 10% discount for members in unified states, your 1986 AMA dues will be $297, less than $1/day for a voice in the only national organization that works for all physicians.

The Kansas delegation hosted a reception to promote the re-election of William J. Reals, M.D.,

(Continued on page 309)

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HYDERGINE® LC (ergoloid mesylates) is indicated for patients over age sixty who manifest signs and symptoms of idiopathic mental decline. It appears that individuals who respond to HYDERGINE LC therapy are those who would be considered to suffer from some ill-defined process related to aging or to suffer from some underlying condition such as Alzheimer's dementia.

Before prescribing HYDERGINE therapy, the possibility that the patient's signs and symptoms arise from a potentially reversible and treatable condition should be excluded. In addition, because the presenting clinical picture may evolve to suggest an alternative treatment, the decision to use HYDERGINE therapy should be continually reviewed.

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liquid capsules, 1 mg

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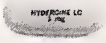
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HYD-1085-13

For Brief Summary, please see following page.

HYDERGINE® LC

(ergoloid mesylates) liquid capsules 1 mg



Indications: Symptomatic relief of signs and symptoms of idiopathic decline in mental capacity (i.e., cognitive and interpersonal skills, mood, self-care, apparent motivation) in patients over sixty. It appears that individuals who respond to HYDERGINE therapy are those who would be considered clinically to suffer from some ill-defined process related to aging or to have some underlying dementing condition, such as primary progressive dementia, Alzheimer's dementia, senile onset, or multi-infarct dementia. Before prescribing HYDERGINE® (ergoloid mesylates), the physician should exclude the possibility that signs and symptoms arise from a potentially reversible and treatable condition, particularly delirium and dementiform illness secondary to systemic disease, primary neurological disease, or primary disturbance of mood. Not indicated for acute or chronic psychosis regardless of etiology (see Contraindications).

Use of HYDERGINE therapy should be continually reviewed, since presenting clinical picture may evolve to allow specific diagnosis and specific alternative treatment, and to determine whether any initial benefit persists. Modest but statistically significant changes observed at the end of twelve weeks of therapy include: mental alertness, confusion, recent memory, orientation, emotional lability, self-care, depression, anxiety/fears, cooperation, sociability, appetite, dizziness, fatigue, bothersome(ness), and overall impression of clinical status.

Contraindications: Hypersensitivity to the drug; psychosis, acute or chronic, regardless of etiology.

Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing HYDERGINE (ergoloid mesylates) preparations.*

Adverse Reactions: Serious side effects have not been found. Some transient nausea and gastric disturbances have been reported, and sublingual irritation with the sublingual tablets.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3-4 weeks.

How Supplied: HYDERGINE LC (liquid capsules); 1 mg, oblong, off-white, branded "HYDERGINE LC 1 mg" on one side, "S" other side. Packages of 100 and 500. (Encapsulated by R. P. Scherer, N.A., Clearwater, Florida 33518).

HYDERGINE (ergoloid mesylates) tablets (for oral use); 1 mg, round, white, embossed "HYDERGINE 1" on one side, "S" other side. Packages of 100 and 500.

Each liquid capsule or tablet contains ergoloid mesylates USP as follows: dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

Also available: HYDERGINE sublingual tablets; 1 mg, oval, white, embossed "HYDERGINE" on one side, "78-77" other side. Packages of 100 and 1000. 0.5 mg, round, white, embossed "HYDERGINE 0.5" on one side, "S" other side. Packages of 100 and 1000.

HYDERGINE liquid; 1 mg/ml. Bottles of 100 mg with an accompanying dropper graduated to deliver 1 mg. [HYD—ZZ24—6/15/84]

Before prescribing, see package circular for full product information. HYD-1085-13

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IMPAIRED PHYSICIAN PROGRAM DIRECTORY

For information concerning the Impaired Physician Program of KMS or to get help for an impaired colleague, yourself or your spouse, please contact the KMS office or the contact person in your area. All information and identities will be held in strictest confidence, and the caller need not identify himself or herself.

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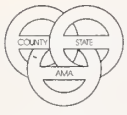
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A New Perspective

LARRY R. ANDERSON, M.D.,* *Wellington*



At the annual meeting of the Kansas Medical Society, their delegates voted to require unification with the American Medical Association. It's the feeling of the KMS membership, especially in these times, that it's the moral and financial responsbility of all physicians to support the AMA, which is without a doubt the logical national voice for our profession.

This unification vote has forced me to reflect on my current position. Although I'm active in my specialty organizations (KAFP and AAFP), my local medical society and the KMS, I dropped my membership with the AMA several years ago because I became disappointed with what I perceived as an organization more concerned with physician incomes than with the American health care delivery system and the people it serves.

I have shared this feeling with Clair Conard, M.D., President of the KMS and James H. Sammons, M.D., Executive Vice President of the AMA, who has supplied me with the *AMA Health Policy Agenda for the American People* which was completed last fall after a two year effort, and with the *Statement of the AMA* made at the July 1985 meeting of the Subcommittee on Health and Environment in the United States House of Representatives. I have reviewed these documents and find my views to be in agreement with these published statements of the AMA.

Perhaps my impression of the AMA a few years ago was incorrect; or perhaps there has been a change in the thinking of the AMA leadership; or both. The AMA still seems reluctant to address those occasional physicians or groups of physicians who abuse our current reimbursement system with excessive fees, but it is starting to acknowledge the unreasonable discrepancy in the arena of cognitive *vs* technical skills.

I have no illusions that cognitive skills will ever be



reimbursed at a significantly increased level, but I'm convinced that excessive fees for certain technical skills will be corrected. I personally feel that the AMA should publicly address this issue, and if it would, its prestige among primary care physicians and with the American public would be immeasurably improved.

The AMA has evaluated, and is now supporting changes in the market place such as increased deductibles, increased coinsurance, alternative health care systems, etc., which will in time reduce excessive fee structures. There has been a definite shift in the thinking of the AMA leadership in the last few years, and for that reason I have rejoined their organization. I encourage those of you still outside the AMA membership to join me and thousands of unwavering AMA members as we strive to develop appropriate responses to current health care problems.

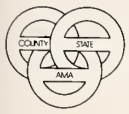
The Interim Legislative Committee on Malpractice continues with its fact finding sessions. As President of the KAFP, I have been given the opportunity to address this committee. There is a good chance for effective legislation during this next session if each of us will continue to discuss the problem of medical malpractice with our patients and state legislators.

*President, Kansas Academy of Family Physicians

Reprinted with permission from *The Jayhawk Family Physician,* September, 1985.

Privilege and Responsibility

MICHAEL E. GORTON,* ***Wichita***

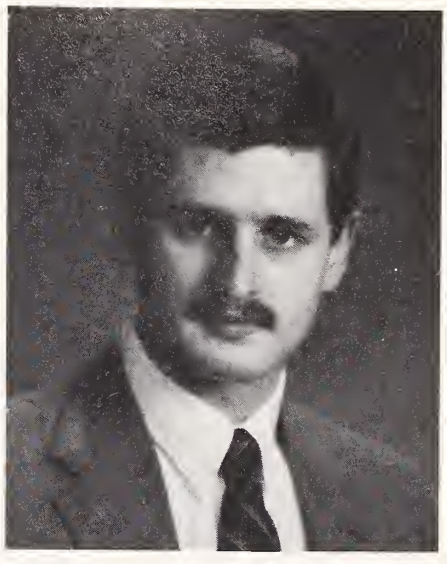


It is our privilege and lifelong duty when we enter medical school to uphold medical standards and mold the future of medicine for the best interest of our patients. The AMA is the only democratic, nationally organized voice for America's physicians, yet it enlists fewer than 50% of its constituents. As a result, the single most important function of the AMA — representation — is severely restricted. Consequently, when Congress hears AMA testimony there is a danger that they may assume that the majority of physicians feel the problem does not warrant their concern. This is the single most important reason we must give our lobbyists the increased support and the innovative ideas they need by becoming active members of the KMS and AMA.

Young physicians in training and practice now, more than ever, realize that decisions made today will affect their future practice and livelihood. During the past four to five years we have seen a shift in AMA strategy, and the AMA is now considered a progressive advocate for young physicians. Such issues as physician surplus and medical malpractice are now primary targets of AMA policy. Evidenced by the defeat of global DRGs through AMA testimony and the recent KMS landmark malpractice legislation, Congress is sensing our new grassroots movement.

Largely as a result of resident physician and medical student efforts, the AMA has adopted policies that strongly oppose unpaid residency positions. The 1985 annual meeting of the AMA created a task force to study funding of graduate medical education, which clearly indicates the AMA's commitment to resolution of this potential problem. The AMA has always supported financial assistance for medical education and will continue to do so in the future.

The ultimate goal of the AMA is to protect and maintain the current system of health care delivery that allows us to provide the American people with the best health care that modern medicine can offer. We must not fall prey to socialized and autocratic medicine as seen in other countries. Physicians know that health care for Americans would be suboptimal with these alternative modes of health care delivery, and we must convey this message to the public. Should they then make an informed choice of



a system that provides less than they are accustomed to, we must democratically uphold that decision. However, America is the land of opportunity, and Americans are not likely to choose to give up the quality of health care they have always known. Let us not apologize for the quality and cost of health care, but instead, join with the AMA in its effort to explain to the public what they currently receive and what they stand to lose. Let us continue to practice quality, cost-effective medicine as always.

Medicine has nothing to offer without competent and diligent physicians. The AMA recognizes that if compensation continues on its present course, we will soon begin to see a two-tier delivery of health care, a concept Americans have historically rejected. The AMA has and will continue to oppose extension of the freeze on physician charges and reimbursement for services provided to Medicare patients as well as the concept of global DRGs.

The AMA is not a special interest group, nor is it a one-issue organization. The success of the association's efforts is based on its ability to maintain and project a balance on all issues of interest to the membership. There are many public health issues supported by the AMA currently before Congress, including requiring school buses to be equipped with seatbelts; identifying and curbing fraud and abuse in the Medicare program; identifying and seeking remittance from those who are delinquent in repayment of medical education loans; increasing the tax on tobacco products; and creating programs de-

(Continued on page 306)

* Medical student.

Women in Organized Medicine

LINDA D. WARREN, M.D.,* ***Hanover***

WHY BOTHER with organized medicine? Especially if you are a woman? This was the challenge to the first Ad Hoc Committee on Female Physicians when it was convened in 1979 to monitor the involvement of women in organized medicine and to find ways to increase their involvement.

Much has been accomplished for women physicians during the past six years, and women leaders have emerged and have won leadership roles at all levels of the federation. This progress has not involved a gender battle or struggle of sexist issues; rather it has been the beginning of the process of mainstreaming women into organized medicine — the concept that has been the backbone of the movement within the AMA. This mainstreaming will be accomplished when women join the AMA in the same proportion as male physicians, and when the number of women in leadership positions is proportional to their numbers in organized medicine.

Women in the AMA have defined their first role as that of physician (not determined by gender). Although they readily admit that the factors that complicate their ability to become involved are usually gender-related, their primary concerns about medicine — both in practice and in professional associations — are not.

The AMA recognized the need for special help in areas of concern to women. The problems of the increasing numbers of women in medicine influenced the second Ad Hoc Committee to prepare a report on Maternity Leave for Residents. It was adopted by the AMA House of Delegates and distributed to all U.S. residency program directors.

Because traditionally many women physicians have not had an opportunity to develop leadership skills, a leadership seminar was prepared and presented by the AMA. A national databank established within the AMA lists more than 600 women physician leaders and is readily available to those who wish to locate a qualified woman physician for a specific position.

AMA leaders have begun networking through a periodic newsletter. Receptions at House of Delegates meetings for women physicians, other delegates, and guests have facilitated contact and substantially increased the visibility of these women.



Because of the sincere and firm commitment of the AMA Board of Trustees, a Women in Medicine project has been created within the federation to provide direction and coordination for AMA activities addressed to women physicians.

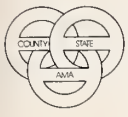
I have touched only on the special things the AMA is doing for the woman physician. To me, this shows their interest in me as a special person. But, as noted above, women surveyed all said that their concerns come first as physicians — and this is what the AMA is all about: representation of all physicians. They have made a special effort to address the concerns of women; they also work with foreign physicians, young physicians, and hospital medical staffs. This is because these groups have one thing in common — they are physicians first, and if they have special concerns, the AMA wants to help them.

The AMA is the only body that can truly represent the American physician in all his/her different faces. We need this kind of powerful organization in our rapidly growing profession to provide us with leadership and representation at the national level and to protect the rights of our patients and ourselves. They have extended their hand to us — a growing group of female physicians. Now it is our turn. We need to enter into this mutually rewarding relationship so that we may help our fellow physicians, our profession, and our patients.

*Member, AMA Ad Hoc Committee on Female Physicians.

Young MDs and AMA Membership

MARK G. BELL, M.D.,* *Salina*



Several points raised at the KMS Annual Meeting should be reiterated for consideration by the general membership. Once these points are considered, it will become apparent why an initially negative response to the resolution by most representatives at the House of Delegates session quickly turned to a nearly unanimous decision in favor of unified membership.

At the meeting it was suggested that the high cost of AMA membership posed a considerable burden on the young physician just beginning practice. This was not brought out by any of the young physicians who were in attendance; in fact, the majority spoke in rebuttal of the point. Speaking for myself — now in private practice for less than two years — I consider the price of AMA membership a bargain for what I receive in return. Moreover, the majority of the young physicians I know routinely spend more than one year's AMA dues for two or three evenings of entertainment or for pleasure trips.

It was also suggested that the AMA does not accurately represent the medical profession. This might have been an arguable point in the 1960s when physicians — along with many others — felt a need to express individuality by forfeiting alliance with their national group. It should be remembered that things in those years were different. Many of us were disenchanted by "organized" anything — be it religious, civic, professional, or political in nature. Whether these feelings were justified or simply a mood of the time is debatable, but this is 1985, and we as a group face threats that could hardly have been imagined then. Bear in mind that we are probably the only profession without compulsory organization membership as a prerequisite for the privilege to practice. Be sure that the attorneys are supporting their lobbyists. The argument that one should not maintain membership in an organization that does not entirely reflect one's own viewpoints would undoubtedly exclude all of us from joining country clubs, churches, civic organizations, or even summer baseball teams. It holds little validity in this discussion.

What it really amounts to is complacency. There is little doubt that the single strongest lobby in behalf of the American physician is the one organized and supported by the American Medical Association. YOU may spend many hours each week writing to elected officials, traveling to Washington to discuss our problems before congressional bodies, or actively organizing political campaigns, but I, frankly, do not. The only people I know who do are all staunch AMA members. The dues we pay to the national association are often the only contribution we make to the fight and is one we should give freely. Sitting blissfully on the sidelines and waiting for the resolution of problems is no longer — if it ever was — a reasonable approach. Complacency must end.

AMA dues are not a real threat to practicing physicians in Kansas. They are miniscule compared with the average malpractice premium. The only viable way to have an impact on the long term effects of the professional liability crisis and increasing government control of the private practitioner is through legislative action, and it is time we all paid our fair share and pulled together in this struggle.

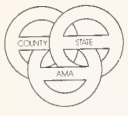
Yes, I voted for unified membership. I believe it is the best way for us to overcome the present obstacles we face and to preserve the integrity of our profession. I hope you will agree.



*Young physician in private practice.

One Patient's Perspective

HARRY SCHWARTZ, Ph.D.,* ***Scarsdale, New York***



IT MAY seem far removed from Kansas, but I want to begin this discussion of unified membership with the account of my illness and my 18-day stay in the White Plains (New York) Community Hospital last January.

I suffered a deep vein thrombosis that was sending pulmonary emboli to my lungs. It was a huge blood clot, and it took a long time for the heparin to dissolve it. But after 18 days, I was much better and ready for a rapid home convalescence. The relevance is this: I had my needed 18 days in the hospital because New York then was a waiver state not governed by DRGs. New York becomes a Medicare DRG state next January 1, and under that system I'm sure I would not get the care I received last January.

Of course, one reason DRGs became law is that there was no effective physician opposition. Whatever the American Medical Association tried to do, it was confronted with the perception that it enrolls and therefore speaks for fewer than one-half of all practicing physicians. As I lay in my uncomfortable hospital bed last January, I was made more uncomfortable by the knowledge that my physician — who was being routinely awakened at 2 A.M. or so by nurses worried about some development in my condition — would be reimbursed with what amounted to a 1982 fee because of the Medicare fee freeze, and yet my physician's cost — especially those for malpractice insurance premiums — were at 1985 levels. Here, too, AMA efforts have been ineffective because legislators tend to see the AMA as just another of the many minority voices in American medicine.

Having recently joined the ranks of senior citizens, I am acutely conscious of the fact that my continued good health depends upon my access to the best possible hospital and physician care when I need it. My illness last January reinforced that awareness. Yet as I look at the Washington scene, I see little concern for the need for continued high quality medical care. Instead, both the executive and legislative branches are dominated by one obsession: cost containment.

My discomfort increased the other day as I read that President Reagan's Secretary of Health and Human Services has decided to press for a uniform fee schedule for all physicians. I learned long ago that not all physicians are equally competent, and not all physicians interact optimally with me when I am a patient — although that may be as much my fault as the physician's.

What comes across to me is that a uniform fee schedule assumes that all physicians are the same and removes the incentive for excellence. After all, why be the best possible family physician or internist, why continue studying hard decades after graduation from medical school, if all you can hope for is the same fee as your dullest colleague? To me that represents a threat to the finest medical care, which I want available when it is needed.

The point is that when the AMA fights for the rights of physicians, it is simultaneously fighting for the rights of patients. Physicians normally are the most effective patient advocates, and daily, lives hang on their decisions. Yet the autonomy and authority of our physicians are being downgraded and denigrated by a host of bureaucrats.

There is no guarantee that the AMA would win all of its major legislative battles ahead in Washington even if every physician in the United States joined and was active in it and in its state and local units. But what can be said with assurance is that the AMA will have much more clout politically if it can claim to speak for all or nearly all physicians and if its income reflects dues and other payments from say 500,000 physicians rather than from only 250,000. A stronger AMA promises a fairer deal for physicians and hence for the patients they care for.

That realization leads me to congratulate you physicians in Kansas who have voted for this important commitment. I hope you are among the leaders who will supply the momentum for a wave of unification decisions to sweep over all state medical societies. In this era when the quality of care is ultimately decided in Washington, unification of AMA membership is one of the most effective pro-patient moves that can be made by any group of physicians.



*Writer in Residence at the College of Physicians and Surgeons, Columbia University; contributor to the *Wall Street Journal, New York Times,* and *Private Practice;* author of *The Case for American Medicine* and other books.

KMS

KANSAS MEDICAL SOCIETY
Newsletter

October 1985

1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

MALPRACTICE UPDATE
BELL COMMITTEE RECOMMENDS CAPS

The Citizens' Committee on Tort Reform appointed by Insurance Commissioner Fletcher Bell completed its work October 8 by recommending that a comprehensive legislative package be adopted by the 1986 Legilsature. Among the many reforms recommended was the so-called "Indiana Plan," which contains a cap on awards, mandatory screening panels, and contingency fee limits.

The action of the 25-member citizens' committee is significant because the Legislature's special interim committee, which has been holding hearings all summer, is looking closely at its recommendations. The legislative committee completed its public hearings October 10 and 11, by taking testimony from several witnesses from Indiana. The Committee will discuss and vote on the many issues being considered November 7 and 8, and a final report will be written and approved on November 21 and 22.

Although it is too early to tell for sure, the Indiana concept appears to be gaining momentum. The Kansas Medical Society and the Kansas Hospital Association have recommended adoption of a modified "Indiana Plan" which contains the following key points:

- Cap on total awards of $500,000, except that awards for future medical care could exceed the limit, up to $1 million.
- Mandatory screening panels, with findings admissible in court
- Contingency fee limits.
- Required itemization of awards.
- Use of structured settlements, especially for future medical care.

In This Issue...

- Professional Liability Update: Bell committee recommends caps
- Health care documentary on TV
- Utah unifies membership
- Tax Reduction Workshop, November 8, Topeka
- RVS study
- Cost containment checklist available
- KANSAS MEDICINE Physician Directory
- Medicina et Lex in KANSAS MEDICINE
- AMA Hotline: 312-645-5323
- Permanent impairment assessment
- To improve communications
- People's Medical Society
- DRGs reconsidered
- Medicare billing nightmare
- KMS Impaired Physician Committee
- AMPAC training
- Medicaid claims assistance
- KMS student member honored

HEALTH CARE DOCUMENTARY ON TV

A one-hour documentary focusing on the impact of costs on health care allocation is scheduled to air on most public television stations Monday, November 4, at 9 p.m. "Health Care on the Critical List," hosted by actor Jack Klugman, highlights several cost containment initiatives and addresses the question of whether health care costs can be controlled without compromising the quality or accessibility of care. Through interviews with patients, doctors, hospital administrators and health policy experts, the documentary demonstrates how alternate health care financing systems work. It shows how DRGs, PPOs, and HMOs can reduce costs by reducing hospital days and expensive tests and procedures. However, in this cost-cutting climate, 30 million Americans with no health insurance may face a tougher time getting free care.

UTAH UNIFIES MEMBERSHIP

The Utah State Medical Assocation House of Delegates has voted to institute unified membership with the AMA effective January 1, 1987. Proponents emphasized that the profession is facing critical times at the national level and thus must have a strong national representation, but that not all are financially supporting their national association. In the same spirit, Virginia is expected to adopt unification at its November convention. At least nine other states are currently considering this issue.

TAX REDUCTION WORKSHOP

Are you overpaying thousands of dollars in taxes each year? Find out by attending the KMS Tax Reduction Workshop to be presented by the Tax Reduction Institute on November 8th, 8-4:30, at the Ramada Inn Downtown in Topeka. To register or for information call KMS at 1-800-332-0156 or 913-235-2383.

RELATIVE VALUE SCALE STUDY

The Health Care Financing Administration (HCFA) has awarded a contract to Harvard University to constuct a relative value scale (RVS) for physicians' services. The AMA will provide advice on the project's overall objectives, directions and research methodology, and will also recruit physicians--through national medical specialty societies--to be involved in the study. The purpose of the study is to enable HCFA to determine if an RVS might provide a workable basis for reimbursement of physicians under Medicare.

COST CONTAINMENT CHECKLIST

The Physician's Cost Containment Checklist, now in its second printing, is a booklet that suggests ways in which physicians can help to slow the rising costs of health care. These booklets are available from the AMA. For prices and ordering information, call 312-280-7291.

THE PHYSICIAN DIRECTORY

You are invited to participate in the PHYSICIAN DIRECTORY, a special feature published each month in KANSAS MEDICINE. This section provides another opportunity for the physician to specify the parameters of her/his practice. This new feature of the journal has no connection with the KMS membership roster, which is published each August. The roster will continue to list, at no charge, basic information about each KMS member.

MEDICINA ET LEX

WAYNE T. STRATTON, J.D., KMS legal counsel, will write a series of short feature articles for KANSAS MEDICINE. You'll find them under the general heading MEDICINA ET LEX (Medicine and the Law), and the first appears in this issue on page 305.

UNIFIED AMA MEMBER HOTLINE: 312-645-5323

Members of the Kansas Medical Society now have exclusive access to the AMA Membership Ombudsman, Wende L. Corbett, by virtue of our status as a unified medical society. This position was mandated by the AMA House of Delegates at its 1984 Interim Meeting as a special benefit to members from unified societies. Ms Corbett will personally handle your inquiries, requests, and complaints as well as coordinate services with other AMA areas in order to provide unified members with exclusive and unique access to AMA services. You may call collect using the unified member hotline, 312-645-5323.

PERMANENT IMPAIRMENT ASSESSMENT

GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT, 2nd edition, is a major source of available literature. Widely used by physicians who evaluate Workers' Compensation claims, this volume contains a wealth of sophisticated current clinical knowledge that is useful in diagnosis, prognosis, and monitoring of patients. The substantially revised and expanded volume was published in 1984 and is available from the AMA at $22.50 to members, $25 to non-members. Direct orders to AMA Order Department, P.O. Box 10946, Chicago IL 60610; note publication number OP254.

REMEMBER . . .

Contractions aren't necessary. Avoid cliches like the plague Be more or less specific. Prepositions are not words to end sentences with. Exaggeration is a billion times worse than understatement. And, who needs rhetorical questions?

PEOPLE'S MEDICAL SOCIETY

The People's Medical Society is a self-described "organization of health care consumers" that repeatedly singles out the AMA as whipping boy in its efforts to build a membership base. Recently, the PMS has blanketed the nation with a series of membership-solicitation letters attacking the AMA and physicians in general and promoting approaches "designed to help people take responsibility for their own health." These letters have been characterized by outlandish allegations and specious arguments. These communications have prompted numerous inquiries by physicians and the public to medical societies. If you need more information, please call the KMS office 1-800-332-0156.

DRGs RECONSIDERED?

The impact of the DRG system on the quality of care will be assessed by various provider groups at a meeting scheduled by the House Budget Committee chaired by Rep. Martin Frost (D-TX). The Senate Aging Committee, chaired by Sen. John Heinz (R-PA), is holding hearings on PROs and premature hospital discharges motivated by the prospective payment system. Heinz was expected to focus on some DRG "horror stories" that have resulted from early discharges and to grill Administration witnesses about program shortcomings.

A preliminary report--the first of its kind, released by the General Accounting Office (GAO)--states that in each of the six communities in which it conducted extensive interviews about the effects of Medicare's new prospective payment system (PPS) on post-hospital care, the view was expressed that patients are being discharged from hospitals after shorter lengths of stay and in poorer health than before PPS.

MEDICARE BILLING NIGHTMARE

HCFA has increased its staff to respond to complaints about Medicare billing problems, especially those resulting from implementation of the new Common Procedure Coding System (HCPCS). Each carrier has been asked to designate an HCPCS coordinator to work directly with HCFA officials. Names of HCFA regional staff persons responsible for HCPCS implementation will be distributed to national medical organizations. Conversion tables showing how the old codes are translated in the new system will soon be available from carriers.

KMS IMPAIRED PHYSICIAN COMMITTEE

All state medical associations now have some sort of program to deal with the problem of impaired physicians. AMA's Board of Trustees reported to the AMA House of Delegates that there are great differences from state to state. Some programs are low-key, keep no records, and provide help only if the physician wants it. Others take a more assertive approach. They investigate and advise the physician whether treatment is needed. The impaired physician who refuses treatment/therapy risks being reported to the licensing board.

The Kansas program is in the latter category. A telephone call to the Kansas Medical Society's Impaired Physician Program initiates a process designed to help the afflicted physician and his/her professional associates, hospital, patients, and family. Early notification is important to avoid serious problems and jeopardy to medical associates.

The call is received by the confidential staff of the IPP and is referred to a member of the KMS IP Committee, who evaluates the information with the assistance of local individuals who are familiar with confidential impairment resources and who retain the troubled physician's anonymity. After adequate information has been obtained, verified and evaluated, counselling and exchange of information with medical associates may be useful. An intervention may then be necessary, and treatment arranged.

AMPAC TRAINING

Phyllis Bigler (Calvin), Garden City, and Dot Meyer (Warren), Wichita, comprised the Kansas delegation attending the first AMPAC Campaign Manager School in Washington DC. Physicians, physicians' spouses, representatives of various state medical societies, and staff members from several congressional and senatorial campaigns spent long hours learning the "state-of-the-art" techniques necessary to run, and run in, a political campaign. Fundraising, media, targeting, budgeting, volunteer coordination, political strategy, and development of campaign themes were a few of the campaign areas covered throughout the intensive week-long meeting.

MEDICAID CLAIMS ASSISTANCE

In addition to maintaining the regular line to the Communications Unit, EDS--in response to SRS request--now maintains a toll-free telephone line for in-state providers. Providers with questions regarding provider enrollment applications, claim resolution and disposition, or Medicaid/MediKan benefits and limitations can contact the Communications Unit at:

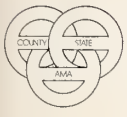
1-800-232-0054 TOLL FREE or at 913-273-5700.

KMS STUDENT MEMBER HONORED

Kevin Hoppock, UKSM-Wichita student, recently was honored for his 1,795 hours of "voluntary community service, personal development, and physical fitness programs." The gold medal, the highest civilian honor by Congress for personal achievements by youth, was presented to Mr. Hoppock by Senate Majority Leader Bob Dole.

Your AMA Delegation

LEW W. PURINTON, M.D.,* *Wichita*



The American Medical Association House of Delegates is a democratic policy making body composed of 371 delegates who represent the entire spectrum of the medical profession. It convenes twice each year — an annual meeting in June or July in Chicago and an interim meeting in December at a designated location.

Shortly after the KMS House of Delegates adopted unified membership, we learned of a proposed $45 AMA dues increase for 1986 which we felt to be inappropriate for our newly unified state. The KMS Executive Committee prepared a resolution, as authorized by the House, to submit to the AMA requesting an exemption of the dues increase for the newly unified states (Kansas and Mississippi). Although Kansas is a small state, your three AMA delegates have a long tenure of service and are well acquainted with delegates from other states. The development of influential relationships has made our voice effective. Therefore, with the support of a midwest coalition of delegations and the other unified states, we promoted our resolution through the intricate procedures required to bring it to the floor of the AMA House, where it eventually passed decisively on voice vote, despite a negative recommendation by the reference committee. This is an example of how things can be accomplished at the national level by your delegates.

Business of the AMA House of Delegates creates a heavy agenda. At the June meeting, we considered 160 resolutions and 72 reports from the Board of Trustees and various Councils. Eight reference committees met simultaneously to hear testimony on reports and resolutions. Their reports were available for subsequent sessions.

Electing members from small state delegations to national offices of the AMA can be difficult. A candidate must be well known with many years of active participation in national organizations, including the AMA, to establish the credibility for



nomination by the Board of Trustees. Election requires a well-run campaign that utilizes brochures, personal mailings, and receptions at the AMA meeting. However, personal contact by our delegation with those from other states plays a significant role in the election and re-election of physicians to important positions.

Kansas can be proud of its representation in the AMA: William J. Reals, M.D., Wichita, delegate from the College of American Pathologists, elected to the prestigious Council on Medical Education; Alex Scott, M.D., Junction City, appointed to the Health Policy Agenda project; and Linda D. Warren, M.D., Hanover, appointed to the *ad hoc* Committee on Female Physicians.

Your delegation consists of three delegates: Lew W. Purinton, M.D., Wichita; Alex Scott, M.D., Junction City; and Kermit G. Wedel, M.D., Minneapolis; and three alternates: Jimmie A. Gleason, M.D., Topeka; Warren E. Meyer, M.D., Wichita; and Linda D. Warren, M.D., Hanover. Be assured that your delegation works hard on behalf of all physicians of Kansas. Please — let us all work together for a stronger AMA.

*AMA Delegate.

AMA Council on Medical Education

WILLIAM J. REALS, M.D.,* ***Wichita***



THE AMERICAN Medical Association was founded in 1847. At that time, only a few medical schools had developed in association with major universities, and the need for physicians in other areas led to development of apprentice type or proprietary schools. There were no standards for the selection of students or faculty, and no premedical education was required.

The first call for the organization of the AMA was issued by the New York Medical Society, and began with the statement, "It is believed that a national convention would be conducive to the elevation of the standard of medical education in the United States."[1] One of the first acts of the organizational meeting of the AMA was the appointment of a Committee on Medical Education. By 1904, the committee achieved full status as a Council and has continued in its important work of medical education for 81 years.

Members of the Council are elected by the House of Delegates following nomination by the AMA Board of Trustees, a system that assures that members of the Council are accountable for their actions to the membership of the AMA through the House of Delegates.

As defined in the AMA bylaws, activities of the Council consist of undergraduate medical education, graduate medical education, continuing medical education, and allied health education. Other areas of activity are physician credentials and qualification, health manpower, and information analysis and publications. Under mandate from the House of Delegates, the Council is responsible for:

- Accreditation of U.S. and Canadian medical schools by the Liaison Committee on Medical Education (LCME), which is composed of the Council and the Association of American Medical Colleges;
- Special studies in undergraduate medical education, either alone or in cooperation with other professional organizations. In June 1982, it published *Future Directions for Medical Education,*[2] which provides a clear direction for medical education in the years ahead;
- Evaluation and accreditation of residency programs through 24 Residency Review Committees established in connection with the American Specialty Boards and seven specialty societies. These organizations form the Accreditation Council for Graduate Medical Education (ACGME);
- The Transitional Year Residency, which has been established in order to meet the needs of the specialties that require clinical experience prior to graduate medical education training;
- Accreditation of institutions and organizations to provide continuing medical education programs; and
- Education for allied health professions and support of the accreditation program conducted by the Committee on Allied Health Education and Accreditation (CAHEA).

The work of the Council is wide ranging and is an essential element in the maintenance of high standards of medical education at all levels in the United States. The Council meets quarterly, and with the support of its Secretary, Richard L. Egan, M.D., and a staff of 100 people, it provides outstanding service to American medical education. As it continues its role in accreditation of medical education programs, it will be interested particularly in the financing of graduate medical education, which is presently a major concern.

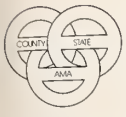
*Dean, The University of Kansas School of Medicine-Wichita.

References

1. History of the Council on Medical Education and Hospitals of the American Medical Association. AMA, p 1, 1959.
2. Future Directions for Medical Education, Report by the Council on Medical Education, AMA, 1982.

Health Policy Agenda

ALEX SCOTT, M.D.,* ***Junction City***



The Health Policy Agenda for the American People (HPA) was created in 1982 to identify the major health care issues of both current and future importance and to develop a coherent plan for responding to them. It is a broad based effort supported by many business, goverment, consumer, and health-related organizations initiated by the AMA. Six work groups are actively participating in its development: Medical science, health professions education, health resources, delivery mechanisms and processes, evaluation assessment and control, and payment for service.

The initial meetings were devoted to development of principles in each area. Following review by the advisory committee, those approved were referred to the steering committee; some were rejected as unacceptable; some were returned to be reworked. In some cases, technological advances (NMR, lithotripters) created a need for reworking. In other areas, methods of payment (DRG) and changes in delivery systems (HMOs, PPAs) mandated change. When the principles were approved and accepted, the work of expanding them into policy began. This project is now nearing completion.

Approximately 350 people from 172 diverse organizations are involved in formulation of the Health Policy Agenda. The members of the work groups and the advisory and steering committees represent not only various medical disciplines and allied fields, but also general industry, insurance, pharmaceuticals, the political and governmental arena, labor, business (Chambers of Commerce and roundtable), state medical societies, and specialty groups. When their work is complete, it will provide a common basis for response to social, economic, scientific, and political issues in American health care. It will represent the best thinking available and will serve as a guide to future policy decisions in legislation, in medical economics, and in practice.



Through this effort, the AMA seeks to guide the future of the medical profession, preserve the best of the present, and continue to care for the health of the American people so that it will lead the world and provide a model to be adapted world-wide for the benefit of all humankind.



*Member, Health Policy Agenda Project.

Medical PACs Unified by Law

ROGER D. WARREN, M.D.,* ***Hanover***



The Kansas Medical Political Action Committee — KaMPAC — is among the oldest non-labor PACs, having been formed in 1962. Its national counterpart, AMPAC, is the oldest non-labor PAC. The Federal Election Commission (FEC) has decreed that AMPAC and all of the state medical society PACs are so closely associated that only one full PAC contribution can be given to any candidate for each election. (A full PAC contribution is $5,000 for senatorial and congressional candidates and $750 for state elected officials.) The primary election and the general election are considered separately. The rules are carefully constructed so that PAC contributions to candidates average less per member than is possible if each member had given individually to a candidate. All contributions from members of an association or group are strictly voluntary and fully reported to the FEC. PAC funds must not be commingled with operating funds of the parent organization.

Money flowing into a PAC treasury is designated as "soft" or "hard." The "soft" money is from the parent organization or from members, corporate funds, *i.e.* funds drawn on corporate checks. By law, this money may be used only for administration or political education. "Hard" money is used for direct candidate support and can come only from personal funds of association members, their spouses, or employees. Our "hard" dollar contributions are used to support candidates without regard to party affiliation, in an effort to elect friends of medicine. KaMPAC and AMPAC were formed to encourage physicians to become active in the political process. We encourage the best use of your political contribution, whether it be of time, talent, or money.

We feel you should register, vote, and volunteer to help in campaigns. Let your patients know your choice of candidates. Get to know your candidate. A few minutes spent getting acquainted now will make it easier to communicate effectively with him/her next year. You should also join KaMPAC and AMPAC in order to positively affect the political process for your patients and yourself!

KMS has a legislative committee that decides policy regarding specific legislation. We also have lobbyists who represent us truthfully and with integrity. We have recently decided to initiate an active public education effort to supplement our legislative efforts. We must either tell our story or accept the changes directed by those who see things differently.

Today important medical legislation is increasingly enacted in Washington. Obviously we need to support AMPAC, but just as obvious is the need to support AMA lobbying and public relations efforts. The AMA does many things for patients — the American public. It represents the best efforts of those physicians who care enough about their patients to work for their best interests; it protects the right of physicians to practice medicine free of crushing governmental control.

The only way physicians can positively affect patient care as a group is to participate in organized medicine: AMA, KMS, KaMPAC, and your component medical society. Freedom has always had a price — a price that has always included, as it says in the Declaration of Independence, "our lives, our fortunes, and our sacred honor."

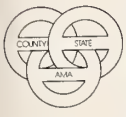
Public pressure is building for public financing of all medical care. The fires of public opinion are heating . . . the pot of medical political stew is brewing . . . and if we as physicians refuse to season and flavor this stew, it may be indigestible to all of us.

*Chairman, KaMPAC.

Unity

New Birth of Medical Freedom

JAMES H. SAMMONS, M.D.,* ***Chicago***



I AM pleased to have this opportunity to address the subject of unified medicine for the readership of KANSAS MEDICINE, which is one of the finest state medical society publications in the nation.

Members of the Kansas Medical Society have been most supportive of the AMA, which we greatly appreciate.

Unified membership with the AMA immediately raises the question of what that membership is worth to you and your society and our physician members. It is worth a great deal, including a 10% discount in AMA dues and access to a broad and growing range of information services.

Unified societies will be provided with increased AMA services and staff support for such things as special projects, AMA briefings on important issues for medical society officers and executives, access to an AMA staff ombudsman, and creation of a unified societies advisory committee consisting of representatives of all unified societies. These and many other AMA benefits to unified societies and their members are important and well worth the payment of AMA dues in their own right.

But as concerned physicians, we have to look much further than that. It seems to me we have to look at what unified AMA membership means in terms of unifying our entire profession and in terms of a kind of new birth of freedom for our profession. Each level of our federation has its own primary focus and concerns at the local level, the medical specialty level and, through the AMA, at the national level. More often than not our concerns are shared, and when we make unified responses, our presence in social, economic and political (as well as clinical) forums is that much more powerful.

One example is the framing of model state legislation by the AMA to address concerns of physicians in the various states. A reverse example occurred in the last Congress when 125 physician leaders from the federation flew into Washington under AMA auspices and successfully lobbied against a federal law to subject all physicians to mandated assignment under Medicare. But while what's happening in one state may or may not affect other states, developments at the national level almost always affect all physicians. So as a profession, and especially at the national level, we need all the unity we can get. The problem is we don't have enough of that kind of unity. This subjects us to "divide and conquer" tactics.



The often-heard statement that the AMA represents less than one-half of this country's physicians is a very large and pertinent case in point. Far too many non-member physicians, and even some medical institutions and organizations, seem to stand alone in solitary preoccupation with the clinical aspects of medical education and practice. They leave it to someone else to deal with socioeconomics, politics, legislation, and regulation. They leave it to others to provide leadership and financial support. Some go as far as to say the AMA puts too much emphasis on the policital aspects of medicine and too little on the clinical aspects. Yet more than 60% of the AMA's annual budget is devoted to assuring and improving the quality of medical education and practice in this country. And just as history shows the AMA was the prime architect of our system of medical education and practice, it continues to play key roles in the accreditation processes and all the rest of it.

Although less is spent on socioeconomic and political activities, these dollars are crucially important

(Continued on page 310)

*Executive Vice President, American Medical Association.

PRESIDENT'S MESSAGE

I cannot recall, either from personal involvement or from reading the history of medicine, a time when the medical profession has faced the crises it faces now — government control, third party tyranny, malpractice suits, loss of prestige. If ever there were a time when physicians need to be unified and pull together, *now is the time!*

The matter of unified membership, coming as it does at this time of crisis, may cause some physicians to lose sight of the critical issues that face all of us. However, it is precisely these crises that have precipitated the decision to strengthen medicine's unity. We need to be stronger and support all of the organizations that help to protect our profession. If we lose our professionalism, both we and our patients will suffer.

A well-known labor lawyer recently made this observation: "Physicians must give up a little of their individual freedom today if they are to preserve for tomorrow their greater freedom to practice medicine as independent professionals. If they don't, and if current trends continue, the physician will be, in fact, an employee as determined by the formal definition of labor law, and he or she will have no effective negotiative option except to unionize."

I am asking all physicians in the state of Kansas to become, or remain, members of organized medicine in your component county societies, the Kansas Medical Society, and the American Medical Association. If nothing else, be pragmatic. The most we have to lose is some money for dues for the AMA.



But if it works — if our membership strengthens our organizations and helps them to represent us more effectively, it will be the most important money we have ever spent.

C. E. Conard, M.D.

President

A Message from the President of the AMA



Dear Friends,

It is with great pleasure that I commend, congratulate, and thank the members of the Kansas Medical Society for adopting unified membership with the American Medical Association. This is a reinstitution of a sound policy, as KMS was unified with the AMA from 1961 until 1972. You are the leaders of organized medicine's pursuit of a strong, efficient, and effective means of professional representation. It is my sincere hope that during the next several years many more medical societies will follow the lead of KMS and adopt unified membership with the AMA.

Our profession, through federation, is acting as a patient advocate. But the resources we desperately need to fulfill our duty to our patients are being threatened at many levels as efforts are made to cut costs with perhaps too little concern for quality of care.

As a member of a unified society, you lend great strength to our efforts. If all physicians support all their medical societies, we can achieve logical divisions of labor, minimize duplication of effort, and maximize our effectiveness in pursuing our objectives for the benefit of our patients and members. We need the support of all physicians.

Just as you have made a commitment to the AMA, the AMA has made a commitment to you. The AMA has frozen 1986 dues at the 1985 level to facilitate the transition to unified membership. Thus, KMS members are exempted from the $45 dues increase for regular members adopted by the AMA House of Delegates at the 1985 Annual Meeting. In addition, KMS members will receive a 10% rebate on their 1986 dues. This amounts to $33 for regular members.

Several other benefits accrue to KMS and its members as a result of unified membership. The AMA has established an ombudsman for unified societies. This AMA staff person has specific responsibilities for answering inquiries and addressing problems of members of unified societies, and is accessible only to members of unified societies via a special telephone number. KMS will have increased input into the AMA via two additional delegates to the AMA House of Delegates and representation on a Unified Societies Advisory Committee which will address the special concerns of unified societies.

Your commitment to professional unity will serve as an example to your colleagues. We plan to encourage all societies to remain or become unified in the hope that the new incentives for unification will spark a movement toward increased physician solidarity and a more vigorous pursuit of medicine's goals.

You have the deep, heartfelt appreciation of the AMA for your courageous commitment to unite, which is even more commendable in these trying times.

Sincerely,

Harrison L. Rogers, Jr.

President,
American Medical Association

EDITORIAL COMMENT

In Support of Purpose

The House of Delegates of the AMA presented the organization with a considerable challenge in its December 1984 decision to embark on a campaign for unification of the profession through physician membership from local organization through state to national. The campaign, as is already apparent, will follow the proven schema, both practical and philosophical, of emphasizing the positive functions and accomplishments at the national level. The message is that these can be greatly enhanced by assuring that the unity of medical profession is measured as completely as possible by its membership at all levels. The challenge lies in the fact that those at whom the effort is necessarily directed are those who are not now members or who are considering withdrawing (perhaps in part because of the effort itself).

But "challenge" can be virtually synomymous with "risk." The carefully considered value of unification warrants both challenge and risk as does its parent concept, democracy. It will take some strong selling. Recognition of this is demonstrated in the broad extent of the project, the fact that an over-all period of five years will be devoted to it, and the understanding that the very conditions that engender dissent are the strongest arguments for unification.

One salutary demonstration of the AMA's value has already become apparent: the reminder of the numerous functions and services it provides but which are too easily overlooked or discounted as its role and determinations in political activities predominate in the public eye. The presentation of this gamut of lesser known services should be a positive reminder to any fair-minded individual that the organization encompasses a broad range of attitudes and purposes and services in fulfiling its obligations to both profession and public.

It should be immediately apparent that no individual can provide the tremendous quantity and quality of educational and functional opportunities that are produced by the existing structure. In denying the value of certain actions, dissenters would detach themselves from the whole. Is there any individual who is in total agreement with all the actions of our public governing bodies? Is the way to express disagreement to resign from the country? Or claim some virtue in refusing some basic civic responsibility? The lesson of democracy is seemingly lost on them and they prefer to forgo the effort of working within the group for change in favor of an attitude they consider a virtuous independence. But whether organizational or governmental, the strength of a body's independence is based on an internal interdependence. Total independence is total isolation.

Groups — whether defined by location, specializaton, or other common denominator — who proclaim the AMA performance in certain areas inimical to their interests are related derivatively to these individuals but are emboldened by the certainty their own limited unity will permit the group to stand effectively in those interests. Can they really provide their members the potency of representation in professional or political efforts that the total organization can command? If they feel deprived of a specific voice in such measure (despite the fact that the AMA deliberately includes specialty representation in its structure), is there any action (or inaction) of the AMA that prevents them from using that voice in the appropriate forums? Can they not command as much or more attention to the group's concerns by participating in this higher form of unification?

In one sense, this dissociation from the essential professional organization, whether individual or group, can retain a superficial benefit. The AMA, whipping boy though it is for those general critics of medical service, speaks with authority and is accorded respect in the courts of public opinion and effect. But even non-member physicians, by their professional designations, will be identified with the total success of the group and receive the benefits of its efforts and status although they don't contribute to its development.

Basically, we are physicians and then go our separate paths — personal interests, practice forms, whatever designation — as we declare our individuality. The profession needs this basic organization of physicians to define and promote common goals within and extend the benefits of our achievements without. Then we can work, as in any democracy, within the structure to influence its direction and purpose. — *D.E.G.*



MEDICINA ET LEX

An Elephant

WAYNE T. STRATTON, J.D.,* *Topeka*

Editor's Note: This is the first in a series of regular columns concerning current subjects of legal interest to physicians. For the sake of brevity and clarity, citations and footnotes will be omitted.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of Kansas Medicine *or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka KS 66603; 913-233-0593.*

It is becoming increasingly apparent that the medical malpractice compensation system is virtually out of control, both in Kansas and elsewhere. Thirty-five hundred Kansas physicians and 150 hospitals cannot support the level of compensation being awarded by our juries.

It appears that the legislature is reaching an understanding of this fact. Since July, the Special Committee on Medical Malpractice has met for two days each month. It is scheduled to complete its study and make recommendations in November.

As various witnesses have appeared to discuss this problem, varying views have been expressed. Like a committee of blind people trying to describe an elephant, they invariably talk from their single and somewhat limited perspective. Insurors, plaintiffs' attorneys, defense counsel, physicians, and the judiciary have all appeared. The plaintiffs' attorneys point to "bad doctors," inadequate peer review, rip-offs by insurance companies, and mismanagement of the Health Care Stabilization Fund. Many physicians believe that the problem lies with excessive contingent fees and nuisance suits. Solutions offered depend upon what part of the elephant is touched.



Legislation can help control the spiraling cost of malpractice insurance. Indiana, California, and Nebraska all have adopted legislation to provide for caps on awards, screening panels, and other relief. Significant savings have been accomplished.

The immediate and short-term solution must be comprehensive legislation by the 1986 legislature dealing with all aspects of the problem. The scope of the problem is only beginning to be appreciated. Insurors — who were able to make up underwriting losses from investment income during the early 1980s — now face significant losses. Manufacturers and other professionals are also struggling to pay substantial premium increases.

Time will tell whether changes in the tort system in Kansas will be sufficient to halt these spiraling increases. The complete and total compensation of every civil wrong may be a luxury that our society is not longer able to afford.

*KMS Legal Counsel

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Privilege and Responsibility

(Continued from page 293)

signed to curb alcohol abuse and to label alcohol beverage containers. The continuing list portrays the basic ideal of organized medicine — a sincere concern with public health.

In addition to the many intangible benefits of representation, the AMA also offers many tangible benefits, such as life insurance and retirement programs, discounts on car rentals, and discounts on patient information pamphlets as well as monthly issues of *JAMA* and weekly issues of *American Medical News*. The AMA also offers *Lifeline*, a weekly cable TV program that brings the most modern, state-of-the-art medical information and techniques to physicians in even the most remote areas. This further demonstrates the AMA's effort to provide equality of health care to all Americans.

The AMA is a multifaceted organization whose primary responsibility is representation of America's physicians, but it also contributes to physician and public education in an attempt to preserve the quality of health care Americans expect. Not everyone agrees with all AMA policies, but membership gives one the right to challenge the issues and to seek to alter them. Membership in KMS and AMA is truly worthwhile. Join us in our efforts to preserve America's most honored profession.



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AMA House

(Continued from page 287)

Wichita, to the AMA Council on Medical Education. Dr. Reals is now serving his second full term on that Council.

Members of our delegation are kept busy at the meetings serving on reference committees, testifying on issues of concern to KMS members, actively participating in regional caucus deliberations, following the various resolutions before the House, and maintaining the many contacts with their counterparts from other states. AMA House meetings provide a unique educational opportunity and you are encouraged to attend and participate. Any member of the Association may present testimony at the Reference Committee hearings and, of course, corridor discussions of the issues provide ample opportunities to express your views.

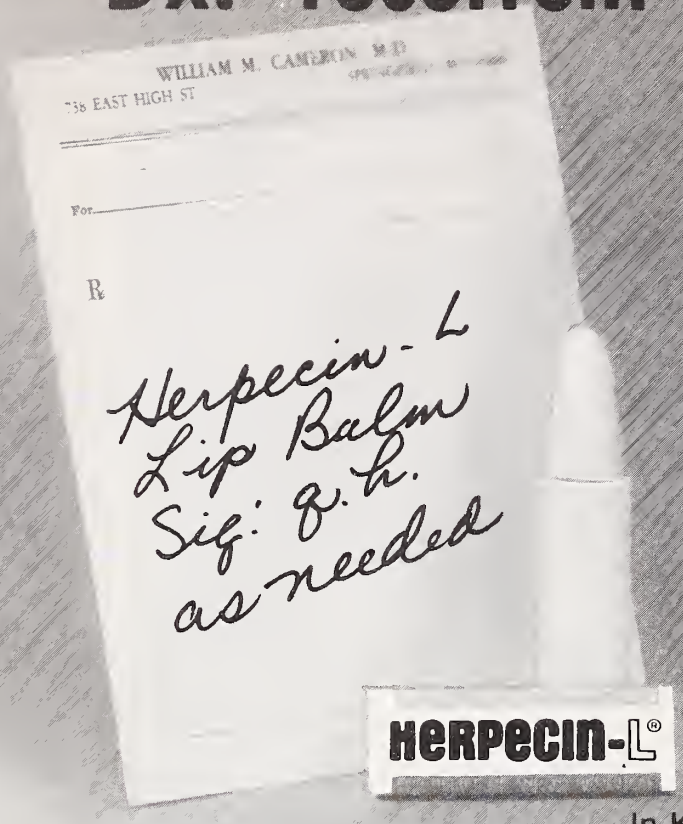
This year, in addition to the elected delegation, the following Kansas physicians attended all or part of the AMA Annual Session: Drs. Franklin G. Bichlmeier, F. Calvin Bigler, Edward J. Fitzgerald, David E. Gray, Joseph C. Meek , Jr., Katherine Pennington, Terry L. Poling, and Roger D. Warren. Also, Clair C. Conard, KMS President, was seated as alternate delegate, and William J. Reals, elected delegate of the College of American Pathologists, was seated with the Kansas delegation.

If you can't come to the meeting you can still be represented through your delegate. Let your delegation know your opinions. You can also prepare a resolution and request that it be submitted to the House. Many AMA policies began with an individual physician who had a good idea and coaxed it through the democratic process.

If you would like additional information of any of the AMA House of Delegates actions, please contact any member of your delegation.

Alex Scott, M.D., *Delegate*
Lew W. Purinton, M.D., *Delegate*
Kermit G. Wedel, M.D., *Delegate*
Jimmie A. Gleason, M.D., *Alternate*
Linda D. Warren, M.D., *Alternate*
Warren E. Meyer, M.D., *Alternate*

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Unity

(Continued from page 301)

to our own future and that of our patients. Precisely because of the superb quality of modern medicine and its manifold benefits for the health of the people coupled with its high and rising cost, it has implicit social, economic and political dimensions, along with what that means in terms of legislation and regulation. So individually or collectively, we can't stand alone. Because what's done in the name of the socioeconomics and politics of medicine — especially at the national level — inevitably affects what we're able to do clinically for our patients, just as it affects every physician, no matter what his/her career choice may be; every medical institution, whether devoted to medical research, education, or the actual delivery of care; and so ultimately, every patient.

For example, any harm done by the prospective pricing of hospital and medical services, whether through diagnosis-related groups or some other method, won't harm just community hospitals and physicians in private practice. Teaching hospitals — especially those in inner cities — are particularly susceptible because they provide extraordinary amounts of care. So harm would be done to the ability of teachers to teach and students and residents to learn, with parallel implications for future generations of practicing physicians. If targets to reduce hospital utilization under the professional review organization program suddenly become strict quotas — and hospitals and staff physicians in some parts of the country say this already is happening — it would affect all hospitals and their medical staffs, again with teaching hospitals at greater risk.

I could go on with this legislative and regulatory litany, but I think I've made my point. Every physician recognizes that his or her first clinical obligation is to the patient.

But we need more physicians who recognize their obligation to stand together as a profession to help meet the socioeconomic and political challenges of the day. This recognition is particularly crucial in view of the national concensus that is building on how best to bridge the gap between the real health care needs of the American people and limited national resources. So our input into the socioeco-

nomics and politics of medicine is vital precisely *because* we are physicians. Due to our extensive education and training, we are in the best position to accurately measure the real needs of our patients, and to help assure that national resources are adequate to meet patients' needs.

When and if changes imposed from without begin to compromise the quality of patient care, we will be the first to know. And we should be the first to let the American people know in a voice that is as clear, strong, and unified as possible. Therein can be found the overriding value of unified membership with the AMA.

Our democracy, from its inception, has been characterized by large, national voluntary associations. They offer us no less than the opportunity to participate in the American dream, to strike a balance with the power of government, to preserve private rights and freedoms, and to pursue the highest possible personal and professional goals. The AMA is that kind of association and offers every physician that kind of value. Each of us, as physician and citizen, has an obligation to make our profession as strong as possible in national association and purpose, and we have an obligation to unify our profession to help it meet its goal of assuring the American people of quality in medical education and practice. We owe no less to ourselves, our profession and our patients. This is really why AMA delegates last December approved the campaign for unified membership. And it's why I encourage you to support unified membership.

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Doubletree Hotel, Kansas City
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5:30 p.m.	Hors d'oeuvres & cash bar
6:00 p.m.	THE MALPRACTICE LITIGATION CRISIS — THE FACTS
7:00 p.m.	Dinner
8:00 p.m.	THE PERSONAL STRESS OF MALPRACTICE LITIGATION
9:00 p.m.	Adjournment

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The **galley proof** is for correction of ERRORS; rewriting of material must be done prior to submission. Authors are urged to carefully check manuscripts and galley proof for errors that could result in inaccurate information.

Drugs should be referred to by generic names; trade names may follow in parentheses if useful. All **units of measure** must be given in the metric system.

Kansas Medicine will print a maximum of ten **references.** All applicable references should be marked by superscripts in the text in the order cited. If more than ten sources are cited, the author should designate the ten most significant to be printed, and readers will be referred to the author for the complete list.

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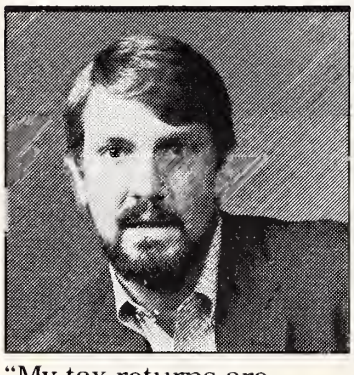
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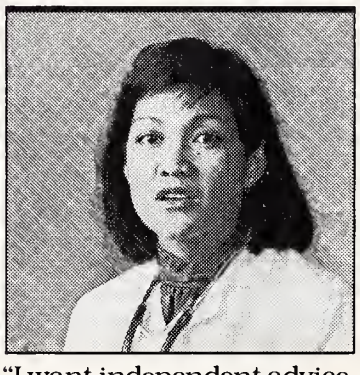
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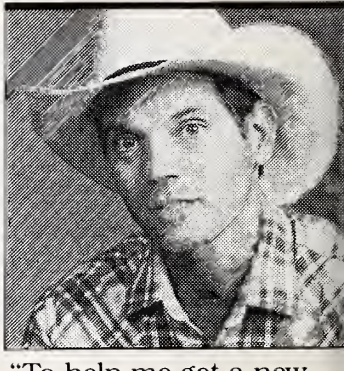
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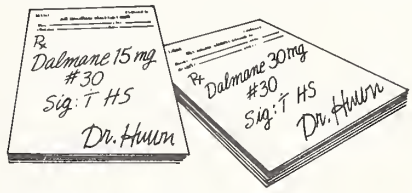
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References: 1. Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



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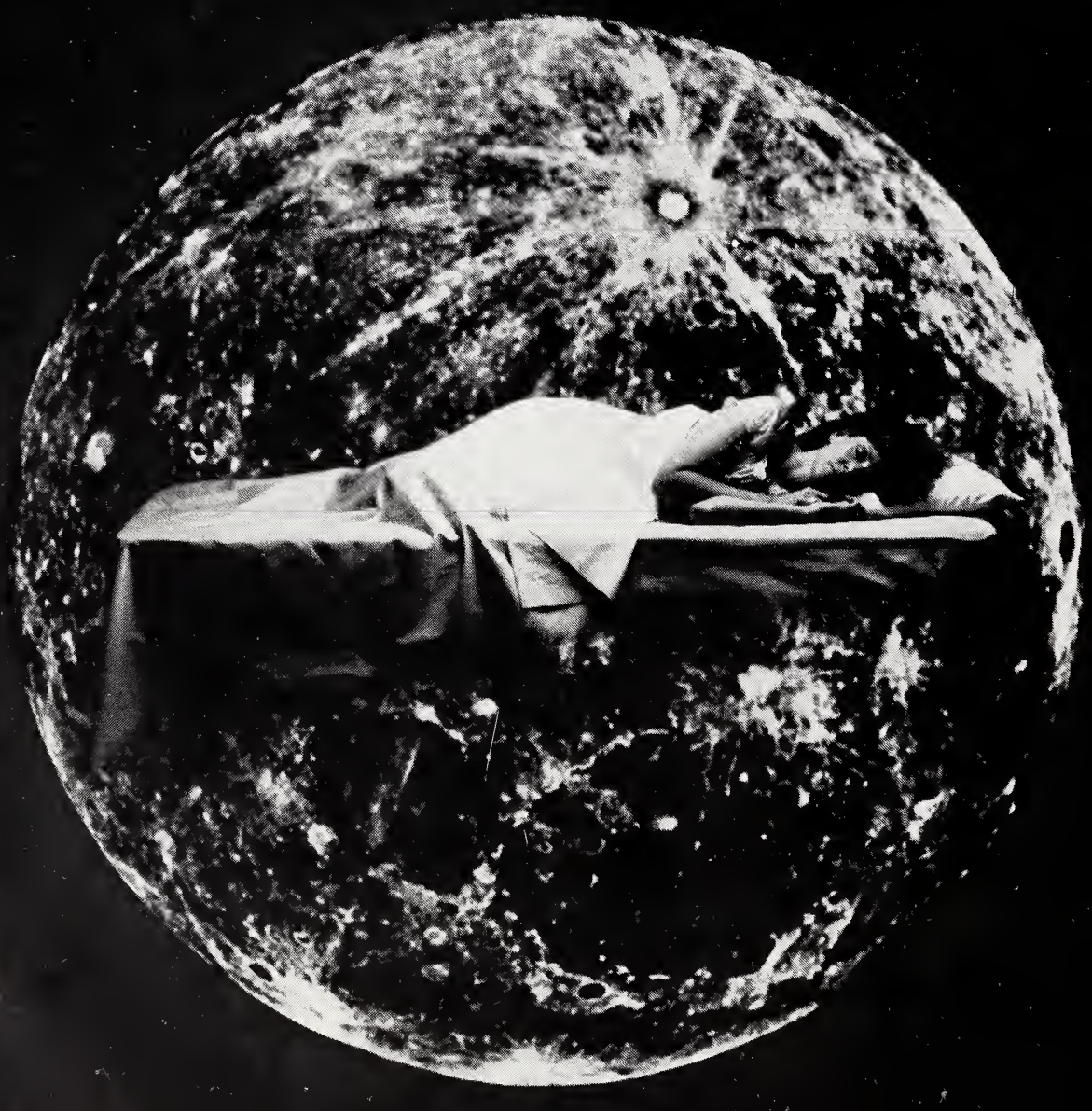
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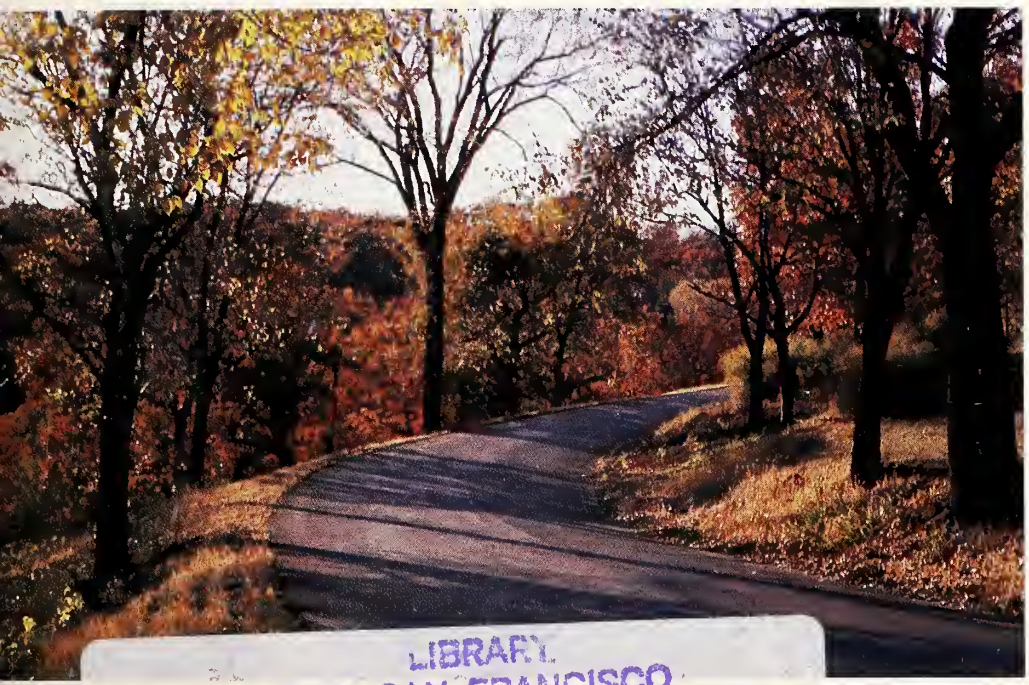


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KANSAS MEDICINE

Volume 86, Number 11, November 1985 ISSN 8755-0059



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THE JOURNAL OF THE KANSAS MEDICAL SOCIETY

KANSAS MEDICINE

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Volume 86, Number 11, November 1985

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THE COVER: This northeast Kansas roadway is a showcase of the state's autumn panorama of color.

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Council Meeting

Report of Meeting held May 5, 1985

The KMS Council convened on Sunday, May 5, 1985, at the Broadmoor Hotel, Colorado Springs, beginning at 11 a.m. Those present were Drs.:

Franklin G. Bichlmeier
F. Calvin Bigler
John P. Brockhouse
Clair C. Conard
Rex R. Fischer
Jimmie A. Gleason
Donald W. Hatton
David A. Leitch
James A. Loeffler
Warren E. Meyer
John R. Neuenschwander, Sr.
Terry L. Poling
Lew W. Purinton
Edwin D. Rathbun
Clifton C. Schopf
Alex Scott
Richard A. Siemens
Richard M. Skibba
Newton C. Smith
G. Rex Stone
Thomas L. Taylor
Don R. Tillotson
Linda D. Warren
Roger D. Warren
Wallace N. Weber
Donald L. Wikoff
Emerson D. Yoder

Staff present were: Val Braun, Gary Caruthers, and Jerry Slaughter.

David E. Gray, M.D., was re-appointed Editor of KANSAS MEDICINE.

The Council approved tentative dates for the Executive Committee and Council meetings for 1985-86 as follows:

Sunday, June 9	Executive Committee
Saturday, August 3	Executive Committee
Saturday, September 21	Executive Committee and Council
Saturday, November 2	Executive Committee
Saturday, January 18	Executive Committee and Council
Saturday, February 22	Executive Committee
Saturday, March 22	Executive Committee and Council
Saturday, April 19	Executive Committee, only if necessary
Sunday, May 4	Council

Lawrence was approved as the annual meeting site in 1989, and the Broadmoor Hotel in 1990.

Professional Liability: The Council approved phases I and II of a proposal to study the medical accident compensation plan. They also authorized Dr. Bigler to request a $100,000 grant from the AMA to support the actuarial study, an educational program in September, and a hospital field study in Kansas.

Interest on Special Assessments: The Council requested a separate accounting of interest earned on the professional liability fund.

PPO: The Council directed staff to work with Sedgwick County and other organizations to carry out the mandate of Resolution 85-29, the feasibility study of a PPO.

Professional Liability Assessment: Staff was directed to compile a list of unpaid assessments by Council districts.

Non-AMA Members: Staff was directed to prepare a list of non-AMA members for councilors for the development of an educational program.

The meeting adjourned at 12 noon.

Report of Meeting held September 21, 1985

The Council convened on Saturday, September 21, 1985, at the La Casa Inn, Lawrence, beginning at 10 a.m. Those present were Drs.:

Carl D. Ambler
Larry R. Anderson
Stuart C. Averill
Franklin G. Bichlmeier
Lee R. Bittenbender
Clair C. Conard
Fredric B. Gnau
Douglas E. Groswald
Richard A. Gruendel
Donald W. Hatton
David A. Leitch
Jack E. Lungstrum
Stephen W. Myrick
John R. Neuenschwander, Sr.
Edwin D. Rathbun
Rex S. Romeiser
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Richard A. Siemens
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Milo G. Sloo
Newton C. Smith
Harl G. Stump
Don R. Tillotson
Roger D. Warren
David Waxman
John W. Weigel
Emerson D. Yoder

Staff present were: Val Braun, Gary Caruthers, Marsha Hutchison, and Jerry Slaughter.

Minutes of the Council Meeting on May 5, 1985, were approved. The next meeting is scheduled for January 18, 1986.

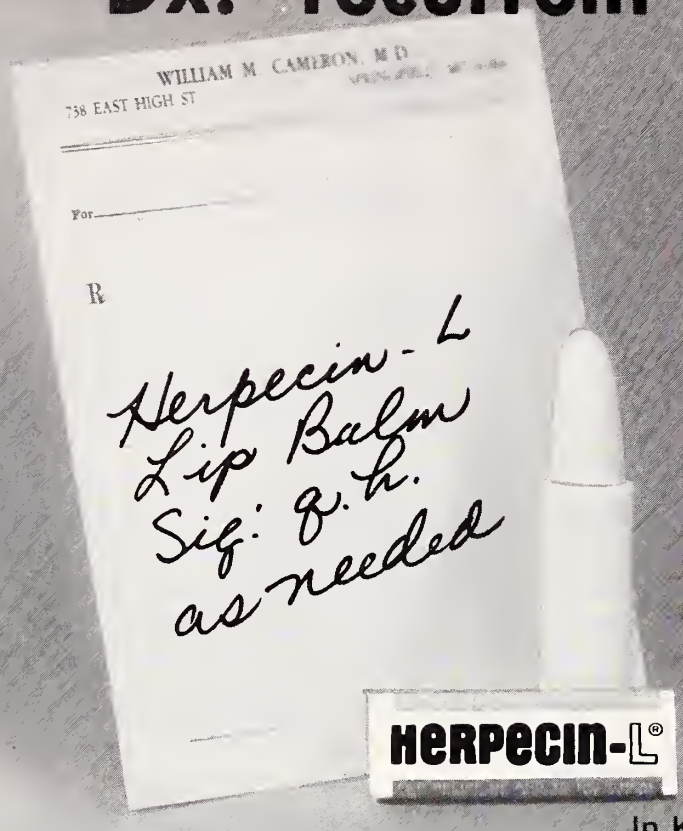
KaMPAC: Marsha Hutchison, Director of Public Affairs was introduced. She will staff KaMPAC and assist with lobbying. Dr. Roger Warren encouraged strong support for KaMPAC and member input on legislative matters.

Insurance: The Council approved the endorsement of International Accident Facilities for group accidental death and dismemberment plan.

MEDISERVE: The Council approved recognition

(Continued on page 316)

Dx: recurrent herpes labialis



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"HERPECIN-L appears to actually **prevent** the blisters . . . used **soon enough.**" DDS, MN

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VOX DOX

To the Editor:

On September 6, 1985, some of you attended a conference in Topeka on escalating malpractice insurance costs. Opinions and suggestions were voiced from the predominately socialistic medical societies of England and New Zealand, from one of the malpractice hot beds in the United States (Florida), and from the AMA. The solution suggested by most participants (except former governor John Anderson, J.D., Chairman of Insurance Commissioner Bell's committee on medical malpractice), was some form of "tort reform" or governmental revision of existing statutes. A draft bill by the AMA for congressional action has been written which "would grant up to $4,250,000 for each state that enacted periodic payments, collateral source offsets, limits on non-economic damages, a decreasing sliding scale for attorney fees, and self-policing provisions" (*JAMA* 254:1153, September 6, 1985).

In the early 1950s, because of rapidly rising individual health costs for the aged and others, there was a push for legislation to change this individual responsibility to a governmental function. The resultant legislation gave the federal government the responsibility for paying health costs of the aged, handicapped, and others who couldn't (or wouldn't) assume their right of responsibility. Medicare-Medicaid has produced profound changes in the practice of medicine through economic pressures and administrative directives. This legislation also took that individual's responsibility for paying the bill and assigned it to everyone who reported an income.

Tort reform as outlined at Topeka and elsewhere is similar to Workers' Compensation legislation. Implicit in this plan is payment to more patients who suffer from "medical misadventure" by a board appointed to administer and judge. In fact, a draft law for the Kansas legislature has been written by Bryce Moore, J.D., with the help of some KMS members, including the immediate past president of KMS, F. Calvin Bigler, M.D. It includes the philosophy of lower award amounts to an increased percentage of those who suffer unfortunate results of treatment or biology or physiology.

Increased compensation demands increased funding! The current problem of increasing costs to

(Continued on page 336)

Have you ever noticed that nearly every time you get "free" financial advice, it costs you something?

Perhaps the last "free" advice you received concerned stocks. Did they go up, or was the broker the only one to gain? What about a "free" insurance interview? Did you notice how whole life insurance was the only answer? How about your mutual funds? No-load funds were probably never mentioned. Stockbrokers, bankers and insurance agents can all be the same. Everyone is trying to sell you a product.

Our firm is different because we sell a service, not a product. Objective financial advice is the service we provide on a "fee-only" basis. No commissions. We can assist you in identifying what you want your money to be doing for you; what resources you have available, and formulate creative ideas to meet your financial objectives. Call (913) 232-3266 and we will send you information on how we may be able to work with you to improve your financial future.



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Orville R. Clark, M.D.

Orville R. Clark, M.D., died October 10, 1985, in St. Petersburg, Florida, where he and his wife had lived since his retirement from surgical practice in 1970. Death resulted from a brain tumor.

Orville was known to many Kansas physicians, although his removal from the Kansas scene undoubtedly means that many of the younger ones were not acquainted with him. He had numerous accomplishments — professional, civic, cultural — and in all, his precise, organized and methodical personality — displayed as well in his surgical expertise — was evident.

He served on the Editorial Board from 1946 until his retirement. During the last 18 years of that service, he was editor of the *Journal*. He brought to it those same characteristics, and it still bears his imprint. Even from that distance, it warranted his designation as Editor Emeritus, the first time the Board had established such recognition. For us, his passing marks the end of an era. — *D.E.G.*

Council Meetings

(Continued from page 313)

of the $32,000 loan to MEDISERVE as a contribution.

Journal: The budget comparison for 1984 and 1985 was reviewed. Staff reported that the Editorial Board is receiving increased numbers of papers from physicians in all areas of the state.

Professional Liability: Progress was reported from hearings of the Citizen's Committee for Tort Reform established by the Insurance Commissioner and the Interim Legislative Committee on Medical Malpractice. Plans for the next legislative session were reviewed. The Kansas Medical Accident Compensation Act has been reviewed by KMS Legal Counsel; another legal opinion will be secured regarding its constitutionality. This will be discussed at the next Executive Committee meeting.

1986 Budget: The Council reviewed the report of income and expenses to date and recommended that dues remain at $220 for 1986. The budget was approved as presented.

Unified Membership: Following discussion of effects of implementation of unified membership, Dr. Conard reminded the Council that the enabling resolution was overwhelmingly endorsed by the House of Delegates, and that it is up to the Council to work as hard as possible to make the program successful.

New Membership Service: Consideration was given to establishment of a toll free telephone line to the KMS Legal Counsel's office for legal consultation by the membership. Expenses of this program will likely be shared with the Kansas Hospital Association. Legal opinions that require considerable amounts of time will be billed to the individual.

The meeting adjourned at 12 noon.

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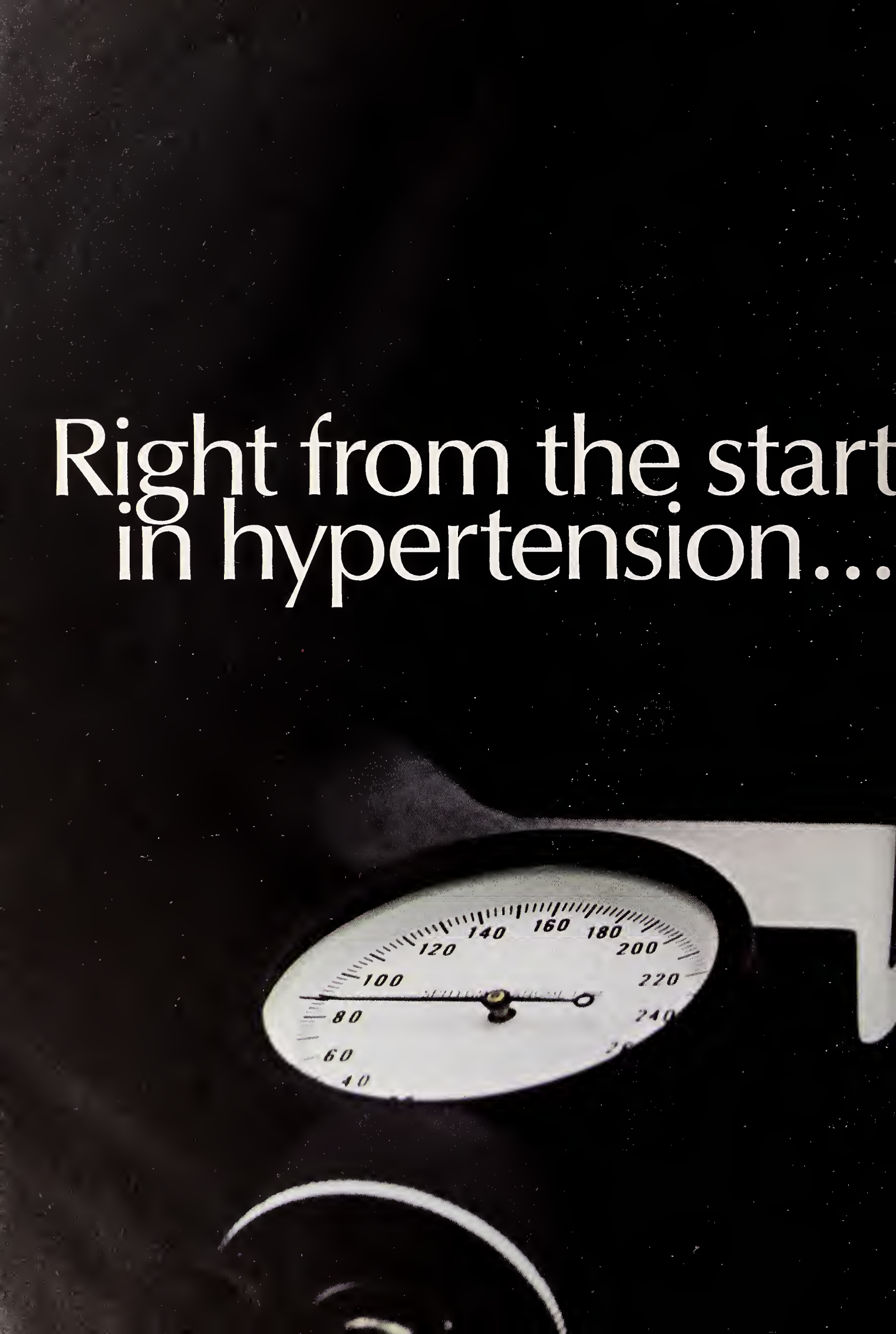
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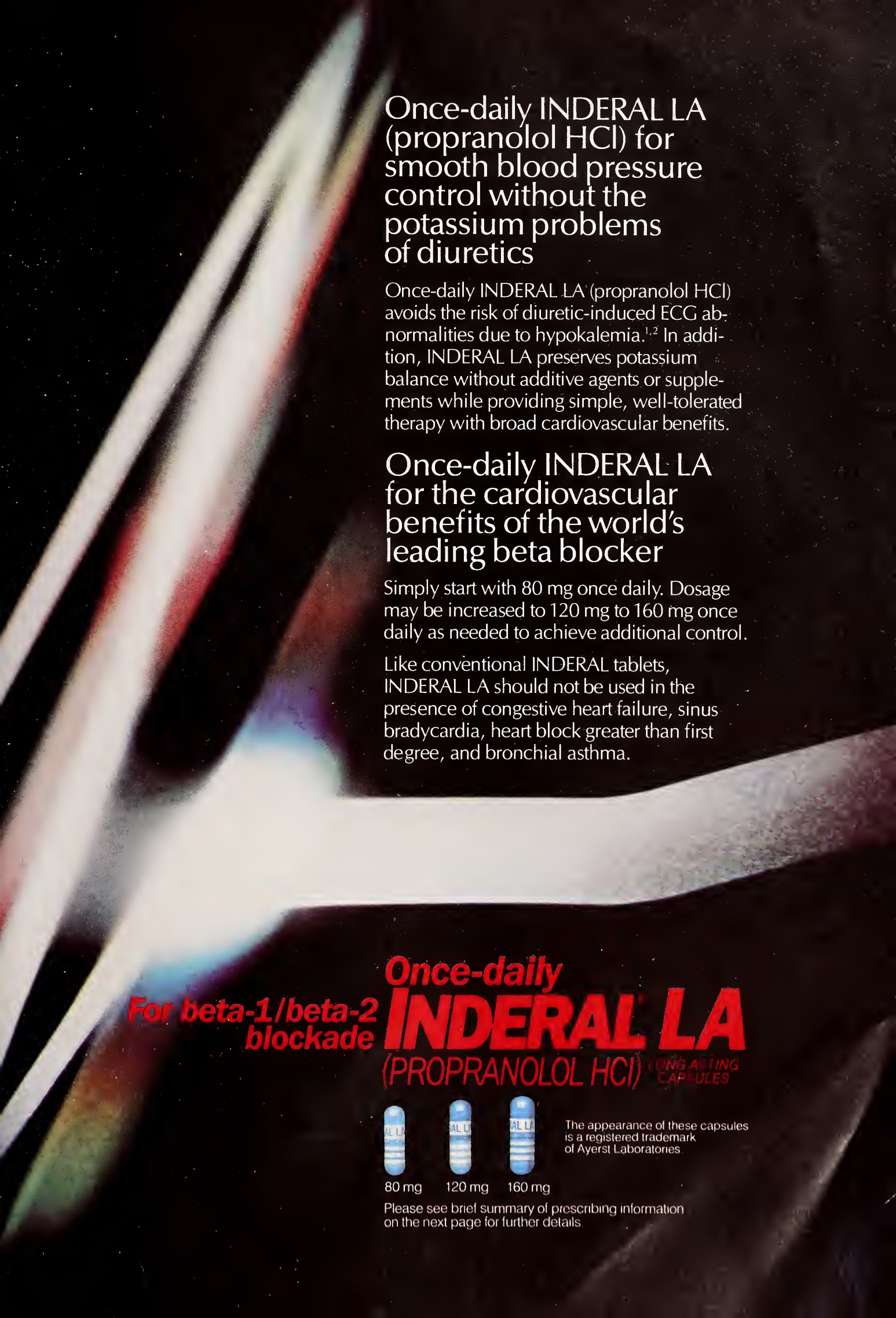
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J-5491 June 1985

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Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[1,2] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily

INDERAL LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

The appearance of these capsules is a registered trademark of Ayerst Laboratories

80 mg 120 mg 160 mg

Please see brief summary of prescribing information on the next page for further details.

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

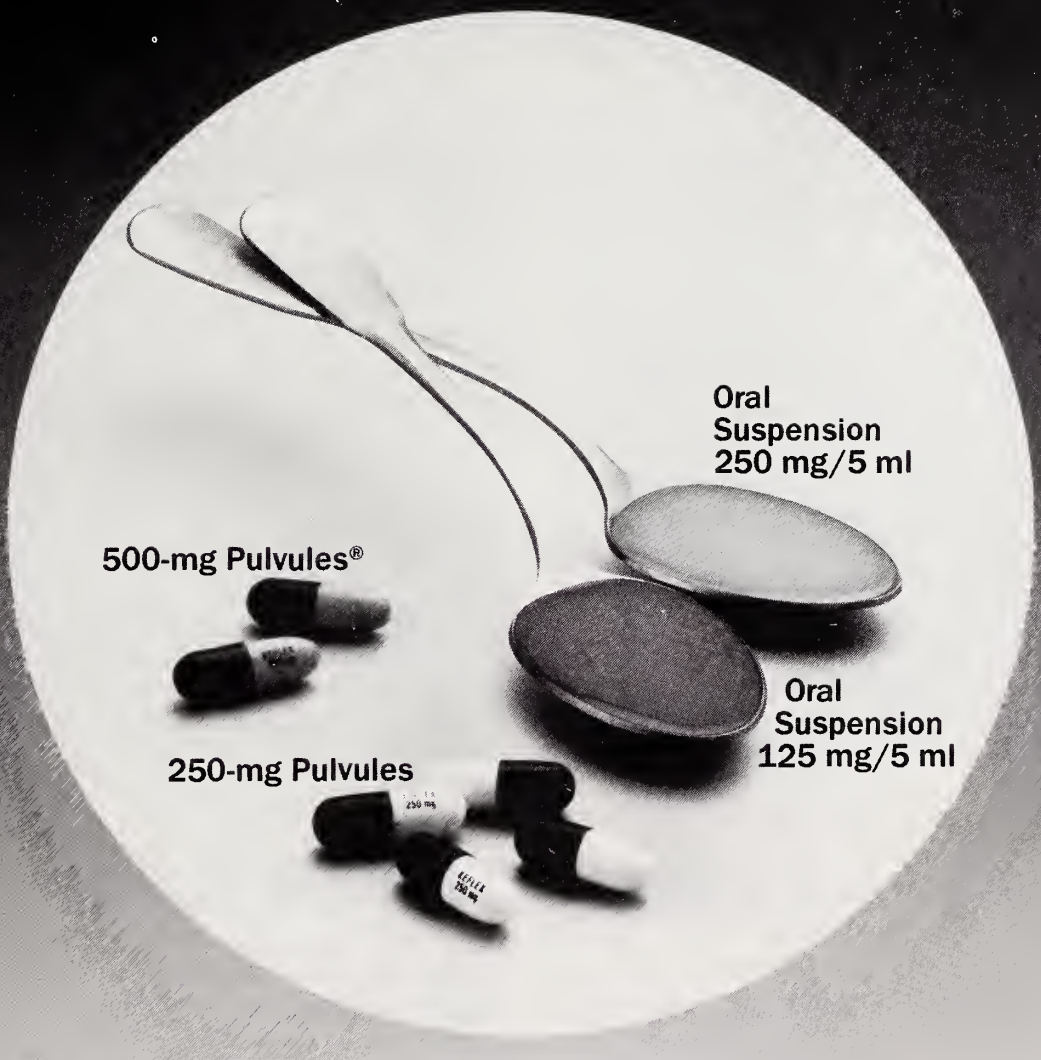
1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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AMA DELEGATE REPORT

Unified Membership

Editor's note: The 1985 House of Delegates adopted Resolution #85-12 that mandates unified county-state-national membership effective January 1, 1986. This is the fifth in a series of short messages to Kansas physicians presented by members of the Kansas AMA delegation.

A strong force is attempting to fragment the medical profession so that we become impotent in determining how medical care will be provided during the remainder of this decade, as well as into the future. This force pits physicians against physicians, physicians against hospitals, hospitals against physicians, and is disguised in various ways — cost containment, hospital privileges, alternate delivery systems, and competition for patients. Medical liability problems as well as a rapidly increasing physician supply, superimposed on a decreasing demand for services are also significant entities.

The only way that these forces can be dealt with is through a strong, unified professional organization at all levels — county, state, and national. The only national component that has a chance to be influential and have impact is the American Medical Association. My experience in Washington, D.C. during the past three years has made it obvious that splinter physician organizations and speciality societies have a minimal impact on policy issues because they are considered special interest groups within the profession.

We must decide *now* as physicians: Do we want our system to deteriorate to the point that government employment is the best deal going? Do we want to be hired hands without significant impact as patient advocates and in health care policy?

Please! If you're a member of your county and state society *and* the AMA, stay unified with us through these trying times. If you're not a member of all of these, please unify with us. You have nothing to lose. We need you NOW!

For less than $2.00 per day you can be a unified member representing Kansas medicine and its concerns.

To paraphrase the late President Kennedy, it is time for each of us to ask, not what can my profession do for me, but what can I do for my profession.

Kermit G. Wedel, M.D., Minneapolis
AMA Delegate

The AMA: A Leader in Medical Science

One of the most important priorities of the American Medical Association for this or any decade is to provide leadership in — and to direct professional and public attention to — the field of medical science. The AMA's historic support of the work of medical researchers has helped make our health care system the best in the world. In a time of conflict in health care policymaking, this unsurpassed record in science and the anticipation of future breakthroughs in the field are attributes that make American medicine worth defending.

The AMA's commitment to this field is expressed clearly in the Association's traditional mission: to promote the art and science of medicine and the betterment of the public health. A key word is "promote," for the AMA is uniquely suited to inform the profession and public about significant developments in medical science. Reports in the general news media on achievements in medical research often cite the *Journal of the American Medical Association (JAMA)*. The AMA has the national visibility and prestige to thoroughly and authoritatively report clinical research findings.

The act on this deep concern, the AMA conducts myriad scientific activities that deserve the support of every physician. Some of these are summarized below.

- The *AMA Council on Scientific Affairs* advises the Association, the profession at large, government, and other health organizations on various aspects of medical science. The Council concerns itself with a variety of policymaking, professional and public information activities, as well as with evaluating and proposing scientific initiatives that

might be undertaken by the AMA unilaterally or with other organizations. The Association publishes annual reports on specific scientific developments monitored by the Council. For instance, recent reports covered the effects of pregnancy on work performance, how Methaqualone abuse limits its effectiveness, the physiological and psychological benefits of exercise for older persons, and new therapies for the pharmaceutical dissolution of gallstones.

- With the *Diagnostic and Therapeutic Technology Assessment (DATTA) project,* the AMA fulfills a vital function on behalf of the profession and the public. The DATTA project studies new medical technologies and procedures to determine their effectiveness and suitability for clinical uses. These evaluations, conducted by panels of physicians expert in their fields, offer indispensable guidance for medical researchers, for practicing physicians, and for national health policymakers.
- The AMA publishes the most authoritative, informed, and current reference source on drugs and drug therapy available today — *AMA Drug Evaluations*. This comprehensive text is provided to one class of medical students each year and its contents have been adapted for transmission via computer.
- The five-digit coding system for medical and surgical procedures, *Current Procedural Terminology,* is produced by the AMA. This system is now used by most third-party payors.
- The AMA is the world's largest publisher of authoritative, up-to-date scienfific information. *JAMA,* which is published in seven languages, enjoys international prestige for its reports on significant clinical developments. The AMA's nine monthly specialty journals provide in-depth, specific information on particular fields of medicine.
- The AMA also disseminates scientific information via electronic communications systems. By early 1985, physician subscribers will be able to use their computers to search for and retrieve material from the entire texts of current issues of *JAMA* and the specialty journals. In addition, the GTE Medical Information Network (MINET®) disseminates up-to-the-minute clinical and socioeconomic information via computer terminal to physicians, allied health professionals, hospital administrators, medical librarians, and others in the health care field. MINET® features the AMA's data base service, AMA/NET, which currently offers six information and bibliographic services. Also, on-line access is available to more than 300 computerized data bases in the AMA library, one of America's most comprehensive and up-to-date.
- The AMA strives to provide information on recent advances in clinical nutrition and other disciplines to physicians, allied health personnel and the public, and to explore and identify special issues that affect personal health. The program seeks to help physicians respond to preventive medical concerns being expressed by the public and to train patients in caring for themselves and in the use of self-monitoring.

The AMA focuses on developments in a wide range of nutrition and personal health topics, including aging, alcoholism, auto safety, boxing, drug abuse, infant mortality, pollution, radioactive wastes, and smoking. Through many of these programs, the Association contributes both to the overall public health and to today's vital policymaking goal to reduce medical costs while maintaining and enhancing the quality of care patients receive.

The AMA's scientific efforts in recognizing and evaluating scientific trends and achievements and reporting on these developments have served physicians and the public well. These activities will continue to prove fruitful if physicians — all physicians — support the AMA.

Letters to VOX DOX should be addressed to the Vox Dox Editor, Kansas Medicine, 1300 Topeka Avenue, Topeka, Kansas 66612.



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SCIENTIFIC ARTICLES

Pregnancy With IUD *in situ*

JOHN H. FALLON, M.D.,* *Indianapolis, Indiana*

THE INTRAUTERINE contraceptive device (IUD) is one of the most popular methods of nonpermanent birth control. Although in concept it has existed since ancient times, alterations and refinements in the past 20 years have boosted its efficacy and hence its popularity. Patients elect an IUD because it is an effective means of birth control, it requires little attention after initial placement, it has a relatively low complication rate (lower in fact than present birth control pills), it is unrelated in its use to the time of sexual intercourse, and it is inexpensive. In addition, its side effects are generally localized; it lacks hormonal — hence systemic — complications.

It is estimated that more than 15 million women are currently using IUDs; if it is assumed that the failure rate of the typical IUD is approximately 2-3%, then 300,000 to 450,000 pregnancies can be expected. Although it is possible to develop IUDs with near zero pregnancy rates, such IUDs are associated with high rates of removal for pain and bleeding. There is little hope of developing IUDs with zero failure rates and acceptable rates of expulsion or removal for pain or bleeding until the mechanisms of how the IUD prevents birth are more clearly understood.

The continuing problem that confronts physicians, then, is how to handle the 2-3% of patients in whom pregnancy occurs. Removal of the IUD can often entail probing of the uterus and traction on the device, both potentially traumatic to the mother and her pregnancy. Leaving the device in place, however, places the woman at risk for spontaneous abortion and septic complications. Some women may elect to have their pregnancies terminated by therapeutic abortion; others will elect to carry their pregnancies to term. The pregnant woman facing this choice must rely upon her physician to advise her of her potential for a term pregnancy and the possible complications — both to the mother and fetus — that may be caused by the presence of an IUD. Ultimately, if the woman wishes to maintain her pregnancy, the physician is faced with the decision of whether or not the IUD should be removed.

Localization of the IUD is an important first step in care. Sometimes the pregnancy is not the result of IUD failure but of IUD extrusion. Ultrasonography is the method of choice for locating an IUD when the string is not visible in the vagina. Occasionally the IUD string is not seen because it has been drawn up into an enlarging pregnant uterus. In most cases, the IUD is in the endometrial cavity and the string has been drawn up alongside it. Longitudinal and transverse pelvic sonograms will generally show the device if it is *in situ*. The advantage of ultrasound is that it provides a three dimensional view; X-ray examination cannot show an IUD in the plane of the endometrium unless dye or instruments are introduced transcervically. In addition, radiation to the developing fetus is potentially teratogenic.

Generally, when pregnancy occurs with an IUD in place, implantation occurs away from the device. Because of this, the device remains extraamniotic. Ultrasonography can show both the IUD and the gestational sac.

If the IUD is left in place, the woman is at increased risk for abortion. In 1970, in some of the earliest work done on the topic, Lewit[1] studied IUD pregnancies among 722 women and found an abortion rate of almost 50% if the IUD remained *in situ*. The devices were subdivided into tailed and tailless categories. Tailed IUDs (such as loops) yielded a slightly higher abortion rate, but their removal greatly improved the chance for live birth. Tailless devices, in order to be removed, require insertion into the uterus of an instrument with which the IUD is hooked and extracted. For tailless devices, the abortion rate after manipulation was more than that prior to manipulation.

In 1973, Alvior[2] studied 201 women; the IUD was removed if three criteria were satisfied: the pregnancy was in the first trimester, the thread was visible,

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and the IUD offered no resistance when pulled. Of the 201, 120 had the IUD left in place and had an abortion rate of 48%. The remaining 81 women whose IUDs were pulled had an abortion rate of 29%. The incidence of subsequent abortion was significantly higher ($P\ 0.02 > 0.01$) in the group in which the IUD was left in place.

More recently, it has been well established that women who become pregnant with an IUD *in situ* are at a particular risk for spontaneous abortion. Shine and Thompson[3] followed 46 pregnancies with IUD *in situ* and found that 49% aborted spontaneously before 20 weeks. An additional four pregnancies (9%) terminated with stillbirths. Vessey[4] reported that in unplanned IUD pregnancies not terminated by elective abortion, 52% ended in miscarriage. This was compared to 17% among women using other methods of birth control — specifically oral contraception or diaphragm — in use at the time of conception. Steven and Fraser[5] reported a 57% rate of fetal loss among 82 women who conceived while using an IUD, more than one-half of which occurred during the second trimester of pregnancy.

In 1981, the effect of IUD usage on the occurrence of fetal loss after the first trimester of pregnancy was reported in a large, multicenter case-control study. Entitled the "Women's Health Study," the project involved 16 U. S. hospitals for a two year period.[6] It sought to investigate the relationship between IUD usage and the occurrence of serious gynecological and obstetrical disorders.

In the study, 539 cases of second trimester fetal loss were compared with 336 matched controls. It was found that among women with an IUD in place at conception that was not removed during the first trimester of pregnancy, the risk of second trimester fetal loss was increased ten-fold relative to the risk among women without an IUD in place at conception. If, however, the IUD was in place at conception but was removed during the first trimester of pregnancy, the risk of second trimester fetal loss was not increased.

It was also found that past IUD use (prior to conception) did not increase fetal loss. No difference was found between non-IUD users, IUD users of the recent past (within one year but not at conception), and IUD users of more than one year prior to conception in the occurrence of second or third trimester fetal loss.

The threat to fetal loss was much greater from septic complications than from any other identifiable source. The data showed that women with *in situ* IUDs had a 26 times greater incidence of septic second-trimester fetal loss when compared to normal second trimester pregnancies. Statistically, the presence of an IUD at conception yielded a six-fold increase in second trimester septic complications. Again, there was no increased risk of sepsis if the IUD was removed during the first trimester of pregnancy. Septic complications seem to be related to infection caused by the presence of the device.

This increased risk of septic complications has been supported by other studies. Sixteen of 19 cases of spontaneous second trimester abortion in pregnancies with an IUD *in situ* reviewed by Eisinger[7] began with either prolonged rupture of the membranes or signs and symptoms of infection. Infection eventually occurred in 18 of the 19 cases. Eisinger felt that not only is the IUD a causal factor in second trimester spontaneous abortion, but that intrauterine infection is the distinguishing characteristic of such cases.

Septic complications also predominated in a study by Wiles and Zeiderman[8] in which eight patients were followed; six suffered fetal wastage and seven had significant maternal complications. The authors note that although recent studies appear to support the concept of an eventual sterile endometrium after two or three cycles in the nongravid state, any IUD string would fit most critria as a "wick" which could possibly allow ingress of organisms from the vaginal pool into the endometrial cavity. This would be enhanced as the string is drawn up into the cervical canal and lower fundus by an enlarging uterus. In addition, even if one assumes a bacterial equilibrium in the nonpregnant state, the changing vaginal flora in pregnancy may alter that stability.

The septic abortions of IUD *in situ* pregnancies may in fact be causally related to spontaneous abortion. A large, five-year study by Kim-Farley *et al.* in 1978 found that pregnant women with IUDs *in situ* had a five-fold increase in spontaneous abortion, and once the abortion had begun, IUD wearers were twice as likely to have a febrile outcome to their abortion. They conclude that "the majority of the excess risk of febrile spontaneous abortion for the pregnant IUD wearers primarily results from their larger increased risk of spontaneous abortion."[9]

Pregnancy with the IUD *in situ* has also recently been related to maternal deaths from spontaneous abortion. In a study of maternal deaths from spontaneous abortion during a three year period reported in the *New England Journal of Medicine*, Cates[10] showed that the risk of death was 50 times greater for women who continued their pregnancy with a device in place than for those who did not. Although the risk

was most pronounced for women using a Dalkon Shield, pregnant women with both loops and coils also had a higher risk of dying from a spontaneous abortion than those without any device. Christian[11] reported five mid-trimester maternal deaths from both shield and loops, all of which resulted from severe septic complications. Four of the five cases involved the Dalkon Shield.

The unique case of the Dalkon Shield deserves mention. A higher risk of spontaneous and septic abortion has been observed with the Dalkon Shield than for any other IUD. Christian was first to report fatal septic maternal complications in IUD pregnancies in 1974.[11] In Cates' study, the risk of death for pregnant women with an IUD *in situ* was three times greater for Dalkon Shield users than for users of any other IUD. Possible reasons seem to be associated with design features unique to this device. The protrusions on the periphery of the Dalkon Shield may cause trauma to the fetal membranes or they may impinge upon the endometrium and contribute to increased susceptibility to infection. In addition, it has been proposed that the tail of the Dalkon Shield provides a nidus for infection which may result in spontaneous abortion. Following a deluge of litigation, the A. H. Robins Company, makers of the Dalkon Shield, have agreed to reimburse costs for removal of all present devices.

Successful pregnancies in which IUDs remain *in situ* do not, however, seem to have any higher risk of congenital malformation. To date there is no evidence of an increased incidence of congenital anomalies in infants who developed with an IUD *in utero*. Tatum[12] reported that of 166 fetuses conceived while a Copper 7 IUD was in place and who grew to a size that allowed adequate examination of the extremities, there was only one congenital anomaly (fibroma of the vocal cords). Although there is not much data, the evidence does not seem to indicate that an IUD has a deleterious effect on embryologic development.

The pregnant woman with an IUD *in situ* who wishes to continue her pregnancy to term presents a dilemma to the physician. At present, recommended and accepted clinical practice calls for removal of an IUD whenever pregnancy is diagnosed. The situation becomes more difficult, however, if the IUD strings are not visible or the IUD cannot be located. If this occurs, attempts should be made to confirm the intrauterine presence of the IUD, most commonly by ultrasound. If the IUD is not accessible, attempts at further manipulation should not be made. The pregnancy may continue with the IUD in position with the patient's awareness of the increased risk of spontaneous and septic abortion. Both the patient and the physician must maintain a close watch for any symptoms that would suggest sepsis or impending abortion. If sepsis occurs or is suspected, the patient should receive appropriate antibiotic coverage and the uterus should be fully evacuated. After evacuation, the uterus should be explored for remaining tissue that might prolong sepsis and increase complications.

References

1. Lewit S: Outcome of pregnancy with intrauterine devices. *Contraception* 2:47, 1970.
2. Alvior G: Pregnancy outcome with removal of intrauterine device. *Obstet Gynecol* 41:894, 1973.
3. Shine R, Thompson J: The *in situ* IUD and pregnancy outcome. *Am J Obstet Gynecol* 119:124, 1974.
4. Vessey M: Outcome of pregnancy in women using an intrauterine device. *Lancet* i:495, 1974.
5. Steven J, Fraser I: The outcome of pregnancy after failure of an intrauterine contraceptive device, *J Obstet Gynecol Br Comm* 81:282, 1974.
6. Foreman H: Intrauterine device usage and fetal loss. *Obstet Gynecol* 58:669, 1981.
7. Eisinger S: Second trimester spontaneous abortion, the IUD, and infection. *Am J Obstet Gynecol* 124:393, 1976.
8. Wiles P: Pregnancy complicated by intrauterine contraceptive devices. *Obstet Gynecol* 44:484, 1974.
9. Kim-Farley R: Febrile spontaneous abortion and the IUD. *Contraception* 18:561, 1978.
10. Cates W: The intrauterine device and deaths from spontaneous abortion. *N Engl J Med* 295:1155, 1976.
11. Christian C: Maternal deaths associated with an intrauterine device. *Am J Obstet Gynecol* 119:441, 1974.
12. Tatum H: Management and outcome of pregnancies associated with the Copper T IUD. *Am J Obstet Gynecol* 126:869, 1976.

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MALPRACTICE UPDATE

The Special Interim Committee on Medical Malpractice voted on its preliminary recommendations at its November 8th meeting. It has tentatively endorsed a $500,000 limit on total awards, with a "safety valve" exception for future medical expenses, up to another $500,000. The recommendation is very close to the KMS/KHA proposal which has been the subject of intense study and debate throughout the summer and fall. The recommendation represents a significant step forward towards resolving the malpractice problem. The interim committee also recommended making the findings of screening panels admissible in court, another key element of the KMS/KHA package. There were about twelve other separate recommendations made by the committee, and a complete report of their findings will be mailed to every KMS member after the committee's recommendations are finalized at its next meeting.

Even with a favorable recommendation from the interim committee, the road is still a long one. Legislative hearings will start all over in January, and physicians must continue to talk with their patients and legislators about the malpractice crisis in order for the reform effort to be successful.

On another front, there has been some extremely good news. The United States Supreme Court recently ruled that the California law which limits pain and suffering awards to $250,000 in medical malpractice suits does not violate the federal constitution. The ruling is viewed as a major blow to plaintiff's attorneys, and it could pave the way for more action at the state level to implement such limitations.

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- Women in Medicine
- Medicaid claims
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- Medical records
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- Retroactive denials
- Hospital facts
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LEGALINE:
1-800-332-0248

Beginning November 15th, KMS members will be able to have their medical-legal questions answered quickly and competently, usually at no charge. In response to an ever growing number of inquiries from physicians on issues such as medical records, contracts,and professional liability, the Executive Committee has authorized a new service which allows members to directly call the KMS General Counsel, Wayne Stratton of Topeka. Widely recognized as an authority on health law and malpractice litigation, Mr. Stratton and his firm will answer member inquiries that require a minimum amount of research at no cost. If the inquiry requires additional time and research that can't be handled immediately, the member will be notified and given the option to have the research done at his or her cost.

• The phone number for the KMS LEGALINE is 1-800-332-0248. •

The service is intended to provide reliable legal advice to KMS members who have medical-legal questions of a technical nature that can't be handled by KMS staff. The cost of the program will be underwritten by KMS, except in those instances where a member's inquiry requires more than a minimum amount of research and time.

NOVEMBER--NATIONAL ALZHEIMER'S DISEASE MONTH

Kansas Task Force on Alzheimer's and Related Diseases, chaired by Lauren K. Welch, M.D., Wichita, is in the process of selecting recommendations for presentation to the 1986 Kansas Legislature. The Task Force was created by the 1985 Legislature. Proposals are the result of public hearings which the Task Force conducted this year throughout the state. Among the 21 measures considered are:

- Establishment of a protocol as a guideline to be used by physicians for evaluation and diagnosis of demented patients
- Establishment of three multidisciplinary service centers in Kansas to diagnose organic dementias; provide education/ training of caregivers; provide counseling; pilot day care centers; teaching nursing homes; and others;
- Development of optimal protocols to be used in postmortem examination for confirming diagnoses of progressive degenerative organic dementias;
- Assure basic and continuing education of professionals (MDs, nurses, LPNs, aides, others) about A.D. and related disorder
- A registry of practicing professionals who have experience in providing service for victims of A.D.

The June 1985 report of the AMA Council on Scientific Affairs dealt with the subject of dementia. The report:

- defines the nature and scope of this national health concern;
- highlights crucial features of the process of diagnosis and evaluation of patients suspected to have a dementing disorde
- discusses long term goals, both for the care of the patient and support of the family;
- outlines therapeutic interventions to manage the patient's symptomotology; and
- provides bibliography in research and training.

If interested in a copy of the AMA report, please contact KMS.

GOLDEN ANNIVERSARY KMS OB/GYN SECTION

The OB/GYN Section of Kansas will be 50 years old next May. The event will be observed at the Section's annual meeting in Topeka. KMS Maternal Health Committee encourages all Kansas physicians who render OB/GYN services to become full or associate members of Kansas Section, ACOG (Kansas Chapter, American College of Obstetricians and Gynecologists). You are also encouraged to become familiar with ACOG Standards of Obstetrical Care. Contact William T. King, M.D., Secretary-Treasurer, Great Bend, tel. 326-793-3501.

)MEN IN MEDICINE

The project has compiled a resource packet on the work patterns, practice characteristics, and incomes of female physicians. Copies of the 63-page document titled "In the Marketplace" are available from Women in Medicine Project, AMA Headquarters, 535 No. Dearborn, Chicago IL, 60610. Tel. 312-645-4391.

EDICAID CLAIMS RESOLUTION

Kansas law KSA 39-708a establishes timely filing for Kansas Medicaid and MediKan claims submission. The law requires that all claims must be received by the fiscal agent currently EDS-Federal) within six months from the date of service. All claims must have final adjudication within 12 months from the date of service. Questions related to Medicaid/MediKan claims processing should be directed to EDS Federal, P.O. Box 4649, Topeka 66604; 913-273-5700.

ANSAS CERTIFICATE OF LIVE BIRTH

KMS Maternal Health Committee, Rex R. Fischer, M.D., recommends that physicians provide the hospitals with as much information as possible prior to the delivery to facilitate the completion of a birth certificate. Birth certificates are important not only as personal documents, but also for gathering statistical data. Their accuracy therefore is paramount. The Kansas birth certificate is currently undergoing revisions. Your suggestions for changes are solicited. Please contact Henry W. Buck, Jr., M.D., Chairman of the subcommittee, 913-841-9200.

EDICAL RECORDS

Records of physicians: availability of information to other physicians. The interest of the patient is paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who had served or are serving the patient. A physician who formerly treated a patient should not refuse for any reason to make his/her records of that patient promptly available on request to another physician presently treating the patient. Proper authorization for the use of records must be granted by the patient. Medical reports should not be withheld because of an unpaid bill for medical services.

RACTICE ALTERED Y INSURANCE?

During the past several months the KMS office has become aware of an increased number of physicians throughout the state who have altered their practices in some way due to escalated malpractice insurance premiums. To aid legislative efforts, a profile is being developed which will indicate the number and extent of modifications being made by Kansas physicians and their impact on the future medical care of Kansas citizens.

To date several names have been received and verified; however, there are undoubtedly many more whose names have not come to the attention of KMS staff. If you are aware of physicians who may fit into the profile, please relay the names to the KMS office at 1-800-332-0156. Your assistance in this compilation will lend strong support and substantiation to our legislative message.

RETROACTIVE DENIALS

Such specialties as pathology, radiology, and anesthesiology are most commonly affected when retroactive denials for inhospital service are made. KMS-SRS Committee, Phillip A. Godwin, M.D., Chairman, suggested that the hospital administration inform all physicians participating in a case of the reimbursement status of a given case. According to the Kansa Hospital Association Director, however, it should be the responsibility of the attending physician to notify all consulting MDs of the medically necessary length of hospital sta.

HOSPITAL FACTS

America's 1984 hospital costs rose only 4.5%, making it the lowest rate of cost increase since 1963. Hospital costs rose 10.2% in 1983 and more than 16% in 1982. The trend in declining rates of cost increase for hospitals has been attributed in large part to MEDICARE's prospective pricing program. Other factors include changes in MEDICAID payment, increased emphasis on cost containment in employee health benefit plans, and a somewhat lower general inflation rate. Thus, hospital admissions dropped by 1.5 million (4%) in 1984, and the occupancy rate of the nation's hospitals stood at 66.6%, which is the lowest level since the American Hospital Association began collecting such data in 1963. Length of stay averaged only 6.7 days in 1984, down from 7 days in 1983. During 1984, the nation's hospitals closed 11,000 beds the first decline in total beds since record keeping began. The number of hospital employees declined by 73,000 (2.3%) in 1984.

POPULATION UNDERINSURANCE

A recent report estimates that 24-37% of the non-elderly population is uninsured or underinsured, depending on the criteri used to define adequate coverage. The report was prepared by the AMA Council on Medical Service and was adopted by the delegates at the AMA Annual Meeting. Those with the highest levels of no insurance and underinsurance tend to be females; part-time workers, the self-employed, and the unemployed; those in poor health; and those at the lower end of the income spectrum.

One approach suggested for assuring adequate coverage is the expansion and liberalization of eligibility criteria under tax-supported assistance programs, including liberalized "spend down" provisions for individuals at marginal income levels--although it was recognized that such an approach is currently unlikely to be implemented. Possible approaches through the private sector include: a dollar limit on the insured's out-of-pocket liability; required catastrophic coverage; requirement of health insurance availability to all employees and their families; and pooling insurance arrangements for the self-employed and those not in the labor force. The report noted that it is likely that society as a whole already bears the costs attributable to inadequate health care coverage, either through lost work-hours and productivity or through defraying the economic burden of uncompensated care.

Carotid Screening for Stroke Prevention

ALEX D. AMMAR, M.D.,* *Wichita*

FIVE HUNDRED thousand new strokes occur annually in the United States at a cost of $8 billion for care of these patients.[1] As many new strokes are diagnosed each year as cancers of the breast, lung, colon and rectum, and uterus combined.[2] Approximately three-fourths of all strokes are ischemic, and the majority of these are due to disease at the carotid bifurcation, either atherosclerotic embolization or thrombosis.[1] Hence, the magnitude of the problem of cerebrovascular disease is clear.

Although most areas of the peripheral vascular system readily lend themselves to accurate physical examination, the internal carotid artery is unique because of its relative inaccessibility to physical examination. The internal carotid artery pulse cannot be palpated (pulsation in the neck is due to the common carotid pulse), the presence of an arterial bruit may or may not identify a significant stenosis, and the absence of a bruit may or may not identify the absence of a significant stenosis (a 30-90% stenosis is needed to produce a bruit).[3] In patients with specific carotid territory symptoms, diagnosis is simple and arteriography is mandatory. It is in asymptomatic patients that controversy arises. The carotid bruit is the sole physical finding that may give a clue to the possible presence of a hemodynamically significant internal carotid lesion in an asymptomatic patient; however, as previously mentioned, the absence of a bruit may not indicate a normal arterial system. The preceding observations coupled with the fact that brain tissue cannot regenerate itself once it becomes damaged, makes the prevention of stroke crucial.

Several observations support the importance of the asymptomatic but significantly stenotic carotid bifurcation atheroma and the potential need for screening. A yearly stroke rate of 4-6% occurs in patients with asymptomatic but significant carotid stenosis (greater than 50% reduction in vessel diameter) as determined by OPG and periorbital Doppler examination[1, 4, 5] With the recent gross and microscopic demonstration of carotid plaque hemorrhage in most carotid plaques,[6, 7] and with the recent finding that many hemorrhagic but asymptomatic lesions will ultimately progress, sometimes rapidly, to symptomatic lesions, [8, 9] casual followup of these patients may by risky. This progression of carotid plaques has been substantiated by serial sonographic and arteriographic studies.[8, 11] Furthermore, and perhaps most importantly, approximately 20% of strokes occur in patients who were previously asymptomatic, that is, without preceding transient ischemic attacks.[12] Lastly, the incidence of cerebral infarction has decreased during the past 15 years,[13] and this decrease has accompanied not only changes in dietary habits and exercise patterns, control of hypertension and the use of antiplatelet agents, but also the rise in carotid endarterectomy. Thus, based on the above factors, screening for significant carotid stenosis would seem beneficial in further reducing stroke from cerebral infarction.

Fortunately, the carotid bifurcation is anatomically located in the neck and can be approached readily with non-invasive screening modalities. This can be done using any of the currently available, highly accurate Doppler velocity or imaging instruments which directly evaluate the status of the cervical portion of the carotid artery. Obviously, for screening to be useful ultimately, the risk of invasive diagnostic and therapeutic intervention must be low. Many recent studies report a combined stroke risk of arteriography and carotid endarterectomy of less than 4% and an operative mortality rate of less than 1%. Long term followup of the operated side reveals a restenosis rate of 1-10% in ten years, recurrent transient ischemic attacks in the order of 8-10% at five years, and 6-8% incidence of stroke at five years (including the operative stroke rate).[1] These results, when compared to the conservative, nonoperative approach (20-30% incidence of stroke at five years), favor the aggressive management of asymptomatic patients found to have a significant carotid stenosis by screening studies.

In this era of cost containment, the cost effectiveness of any mass screening endeavor becomes important. Unfortunately, the cost effectiveness of mass screening for carotid artery disease is not known. Although the vast majority of strokes occur in patients above 50 years of age, the cost of screen-

(Continued on page 330)

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Transient AP Elevation in Children

PAKIT VICHYANOND, M.D., *Parsons*

ALKALINE PHOSPHATASE (AP), an enzyme commonly found in the liver, skeletal system and intestine, is among one of many routine laboratory determinations included in the frequently ordered "hospital profile." Significant elevations of this enzyme usually bewilder physicians and lead to extensive workups to determine the cause and nature of the elavations. A distinctive syndrome of highly elevated alkaline phosphatase from an unknown cause in children has been described.[1] We report two cases of "transient benign hyperphosphatasemia" in which the chemical abnormality resolved completely without any further clinical consequences.

Case One

A 10-month-old male presented with slow weight and height gain. Past history included the presence of a heart murmur which was felt by a cardiologist to represent a mild case of pulmonic stenosis. His left inguinal hernia was successfully repaired at 2 months of age. Prior to this visit, he had recovered from an episode of ear infection, vomiting, and diarrhea. Workup for his failure to thrive included a chemstry profile which revealed an AP level of 1055 IU/L (n = 50-155 IU/L), SGOT of 34 IU/L (n = 15-60 IU/L), SGPT 46 IU/L (n = 5-25 IU/L), LDH 332 IU/L (n = 100-250 IU/L) and CPK 383 IU/L. Calcium and phosporus levels were within normal range for age. Other tests for failure to thrive were all negative for any significant diseases or conditions. Two weeks later, the AP level was 438 IU/L. He remains well and continues to grow with the velocity of growth paralleled to the 5th percentile range for his age.

Case Two

A 13-month-old boy developed two episodes of staring spells and unresponsiveness without any abnormal movement after recovering from recurrent respiratory tract infections. An EEG and a CAT scan were normal. This "staring and unresponsiveness" did not recur, but he went on to develop choking spells and diarrhea, during which the "chem 26 profile" was drawn. The profile showed AP of 3120 IU/L (50-155 IU/L), SGOT 75 IU/L (15-60 IU/L), LDH 360 IU/L (100-250 IU/L), calcium 9.3 mg/dl (8.8-10.8 md/dl), and phosphorus 4.8 mg/dl (4.5-6.4 mg/dl). AP isoenzyme showed 14.5% to be a heat stable fraction indicating that the majority of the elevation was due to heat labile fraction (bone fraction). The bone survey was normal. Parathormone was within normal limits. Diarrhea gradually resolved during the next three weeks. AP, redetermined four weeks later, was 288 IU/L. The patient continued to do well and had no further significant problem except for a few minor upper respiratory tract infections.

Discussion

In recent years, several reports describing transient elevation of alkaline phosphatase (AP) in children without clinical evidence of hepatic and skeletal diseases appeared in medical literature.[2-5] The enzyme was found to be elevated up to 20-30 times the adult norm and usually returned to normal value within two months. These patients were mostly under 3 years of age.[6] Solomon, in 1977, coined the term "transient hyperphosphatasemia of infancy" to describe this syndrome.[1] Common presenting signs and symptoms were acute and chronic gastrointestinal problems such as vomiting and diarrhea,[3, 7] failure to thrive,[2, 7] prolonged upper respiratory tract infections,[2] and convulsions (mostly febrile convulsions).[2] The syndrome was observed in the normal population as well as those with malignancies.[4] Available long term followup data indicated no serious adverse outcomes among these patients.[1, 2, 4]

In humans, three major sources of AP are bone, liver, and intestine. The bone AP fraction will lose up to 80% of its activity upon heating the serum at 56 C for ten minutes. The major fraction of elevated AP in previous reports, including one of our patients, was from bone.[1, 2, 4] However, another band of anodal AP enzyme with minor differences in migratory activity from liver AP fraction was observed by electrophoresis.[3] Although gastrointestinal symptoms were common among patients in which anodal AP enzymes were found, laboratory evidences suggested that this anodal fraction derived from the liver rather than the gastrointestinal tract.[3, 6-8] *(Continued on page 331)*

From the Labette County Medical Center, Parsons.

PRESIDENT'S MESSAGE



One of the duties of the President of the Kansas Medical Society is to visit — when invited of course — the 19 Council districts in our state. I have been doing this. Although I was born, raised and educated in Kansas, I have been astonished to rediscover the expansiveness and beauty — the rolling hills of the Northwest, the pecan groves in the Southeast, and the foliage in the Northeast. Of course, living in Dodge City, I was already aware that Southwest Kansas is the prettiest part of the state (an obviously unbiased comment). However, the real treasure of Kansas is its people who still have time to be concerned.

There are some disadvantages to the distances involved, however. Some societies I visited are poorly organized and meet only once or twice a year because of the long distances required for physicians to get together. This results in less communication and collegiality with their colleagues, and hence minimal involvement in helping to solve the problems that face the medical profession.

I have discovered that we are neglecting one of our most important allies in the struggle to inform the public — our medical auxiliary. My wife has become knowledgeable on the malpractice crisis and often has a greater impact when she speaks before auxiliary groups than I do, because she does not have as closely held a vested interest. I have been dismayed to discover how few medical societies meet regularly with their auxiliaries. The most unique arrangement I have discovered is that of the Ford County Medical Society. Physicians and spouses meet monthly for the social hour and dinner, and then separately in their respective groups. The advantages are many. The cost is included in their annual dues, and attendance has been in excess of 90%. The auxiliary is greatly strengthened. Communication within the medical profession is enhanced.

If your society is not doing this, perhaps it is something you might wish to consider. Anything that promotes communication can only help to achieve our goals.

Leonard, M.D.

President

EDITORIAL COMMENT

The Undiscovered Country

The human mind has long prided itself on its superiority over the minds of lower animals by virtue of its ability to reason. Praiseworthy (although questionable) as this ability is, it has set in motion a long chain of intellectual events which have done much to complicate the lives of those so endowed. This reasoning function produced a need for orderliness in personal and public behavior which in turn gave rise to the whole scheme of laws by which human activities were presumed to be directed. (The term "law and order" is not just a happenstance marriage of words.)

This process might well have had the desired purpose of comfortably regulating life except for the fact that beyond the limits that could be reached by formal lawmaking, there were requirements for reasonable and responsible behavior that were necessary if humanity was not only to survive but provide justice and equitability to the infinite variety of the members. This more rarified concept produced a whole new area of intellectual practice — the philosophies — and while there has been a continuing effort to arrive at an overall philosophy to cover the whole human effort, each emerging discipline was developing its own version of propriety. None has been more deeply involved than medicine.

Since humanity was confronted with one overriding reality — the certainty of death — it is not surprising that this termination of life would be the focus of both the specificity of law and the moral restraints imposed by the ethical concept. Certain instances of causing death were legitimized. Self-defense, of course. Combat, extending as far as power permitted, was understandable and, as inflicted on the enemy, causing death was not only accepted but glorified. The unwanted — female infants beyond the number needed for future domestic purposes, deformed infants since they represented the effects of evil spirits or would attract their attention, the elderly incapable of further contribution — were properly disposed of in the interests of the group. Ritualistic sacrifices, whether sought or resisted by the condemned subject, were counted not only acceptable but necessary. But in all of these were the seeds of moral interpretation which would bring increasingly the ethical determination that life was so desirable (however dangerous) that death was abhorrent and to be resisted by any means the mind could devise.

This deep conviction that life should be maintained has been complicated by unforeseen developments reflecting not only more dramatic and enveloping ways of both causing and preventing death, but also an exponential growth in demands for the rights of individuals. Little wonder that the concept of euthanasia, originally intended to convey a passive relief from the agonies of death, has become identified with a distinctly active participation in terminating life — and that physicians are so intensely involved. It has become essentially a struggle between the capability of those individuals to decide for themselves as opposed to something defined as the public good by the judicial element.

Predictably, emotions have run high in the debate, but that is one of the prime characteristics of ethics: the passions generated by such matters, although less tangible, run deeper than those stemming from more specific limits of law. An incessantly immature medical technology has appeared, rapidly producing the survival of individuals who would, not long ago, have departed by accepted processes. Coupled with world-enveloping communications that bring all life into the subject and since ethics is inherently an individual matter, everyone becomes an ethicist.

By its fundamental nature, medicine has been both producer and product of the profoundest ethical principles. Dedication to the preservation of life has been both professional foundation and social charge. But the last century has transformed miracles to the commonplace. No longer are life and death a matter of positive and negative. A multitude of stages in between have emerged, shifting the focus to include not just retention of life but the quality of that life. Euthanasia is no longer an esoteric doctrine, but an emerging point of practical medical function, and we are confronted with defining the ethics of ethics.
— *D.E.G.*

MEDICINA ET LEX

Landing With Your Wheels Up

WAYNE T. STRATTON, J.D.*, *Topeka*



Editor's Note: This is the second in a series of regular columns concerning current subjects of legal interest to physicians. For the sake of brevity and clarity, citations and footnotes will be omitted.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE *or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka KS 66603; 913-233-0593.*

THERE IS AN OLD SAYING among pilots that there are two types — those who have landed wheels up and those who will.

Unfortunately, in this modern society there are two types of physicians — those who have been sued and those who will be sued. These remarks are directed toward the latter group.

In today's environment, lawsuits must be accepted as an inevitable risk of the practice of medicine. Frequently, they come without warning when the physician receives a letter from an attorney or is served with a summons. In many instances, there has been no expression of dissatisfaction by the patient.

Physicians who have been sued should expect to experience immediate emotional reactions. Varying feelings of hurt, anger, guilt, and anxiety are to be expected. It is impossible to devote one's life to giving care, with the accompanying irritation of dealing with the bureaucracy of public and private compensation programs, without feeling betrayed and hurt when sued by a patient. These feelings are natural and ordinarily dissipate fairly soon.

A physician who is sued should not even consider completing or changing the record. It is frequently said — and it is certainly true — that the best defense against a medical malpractice action is an accurate record of the medical care rendered. The record is never perfect in any case that involves medical malpractice, and there is a temptation to modify the record to express what was actually accomplished. Nevertheless, any change not made contemporaneously with the care given will be interpreted as an admission of guilt. What may otherwise be a defensible case will become indefensible if the record is altered.

The physician should consult freely with the lawyer appointed to defend the case. The successful defense of a medical malpractice case involves a partnership between the physician and the lawyer, one providing the medical input and the other the legal. The physician should feel free to call or consult with her/his attorney. The attorney will welcome this involvement and will want to fully inform the physician concerning the legal system and what should be expected. The attorney may ask that the physician attend depositions or actively participate in some way in the defense of the case. If possible, the physician should do so.

An immediate resolution of the matter should not be expected. Physicians frequently are unable to understand the necessity for the length of time it takes for the judicial system to function. Many safeguards are built into the code of civil procedure to avoid unfair tactics or intemperate decisions. Cumulatively, they can add up to a lengthy period.

(Continued on page 334)

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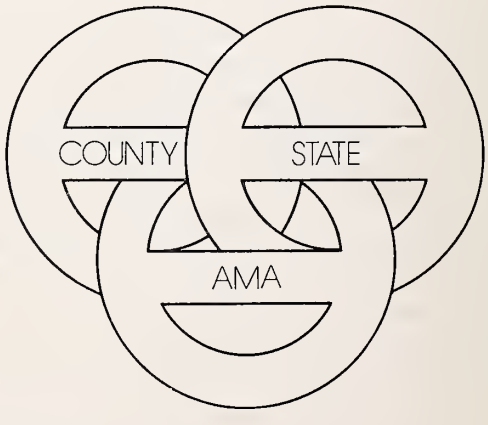
Carotid Screening

(Continued from page 325)

ing all asymptomatic individuals older than 50 years would be prohibitive. For example, the cost of a noninvasive carotid survey at two hospitals in our community approximates $225 per patient. This says nothing of the cost of further workup (arteriography) and treatment (carotid endarterectomy) if a significant stenosis is found on noninvasive testing. Consequently, as in other areas of preventive medicine, screening individuals at highest risk of ischemic stroke would improve the cost-benefit ratio. These individuals might include those with a strong family history of premature atherosclerosis, generalized vascular disease, diabetes mellitus, hypertension, and hyperlipidemia. Just as screening for cancer has increased the detection of early, more treatable lesions, screening for carotid disease would be expected to detect significant lesions before they produce drastic consequences.

References are available on request from Dr. Ammar, Wichita Surgical Group, 818 No. Emporia, Suite 200, Wichita KS 67214.

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AP Elevation

(Continued from page 326)

Etiology of the elevation of AP in these patients remains speculative. Inferred from a study in laboratory animals, AP — as well as many other enzymes — could be induced to be released from the organ of origin during episodes of viral infections.[1, 9]

In summary, we bring to the attention of those who provide health care to children the uniqueness and the benign nature of the syndrome of transient hyperphosphatasemia in children. A lack of awareness of this syndrome could lead to an unneccessary and exhaustive search for its cause, unnecessary parental and physician anxieties, and rising medical costs. Redetermination of AP level in three to four weeks will usually reveal a return to its normal value. Prolonged observation seems to be the most prudent alternative course in the followup for these patients.

References

1. Posen S *et al:* Transient hyperphosphatasemia of infancy — An insufficiently recognized syndrome. *Clin Chem* 23:292-294, 1977.
2. Lockhitch G *et al:* Isolated elevation of serum alkaline phosphatase. *J Pediatr* 105:773-775, 1984.
3. Weime RJ: More on transient hyperphosphatasemia of infancy: An insufficiently recognized syndrome. *Clin Chem* 24:520-522, 1978.
4. Steinherz PG *et al:* Transient, marked, unexplained elevation of serum alkaline phosphatase. *JAMA* 252:3289-3292, 1984.
5. Asanti R *et al:* Serum alkaline phosphatase in healthy infants: Occurrence of abnormally high values without known cause. *Ann Pediatr Fenn* 12:139-142, 1966.
6. Rosalki SB, Foo AY: More on transient hyperphosphatasemia of infancy. *Clin Chem* 29:723, 1983.
7. Weiber H *et al:* Atypical anodally migrating alkaline phosphatase isoenzyme in children and its relation to abdominal pain (letter). *Clin Chem* 29:593-595, 1983.
8. Rosalki SB, Foo AY: Origin of anodally migrating alkaline phosphatase isoenzyme in hyperphosphatasemia of infancy. *Clin Chem* 29:1444, 1983.
9. Rosalki SB, Foo AY: Transient hyperphosphatasemia of infancy: Four new cases and a suggested etiology. *Clin Chem* 26:1109-1110, 1980.

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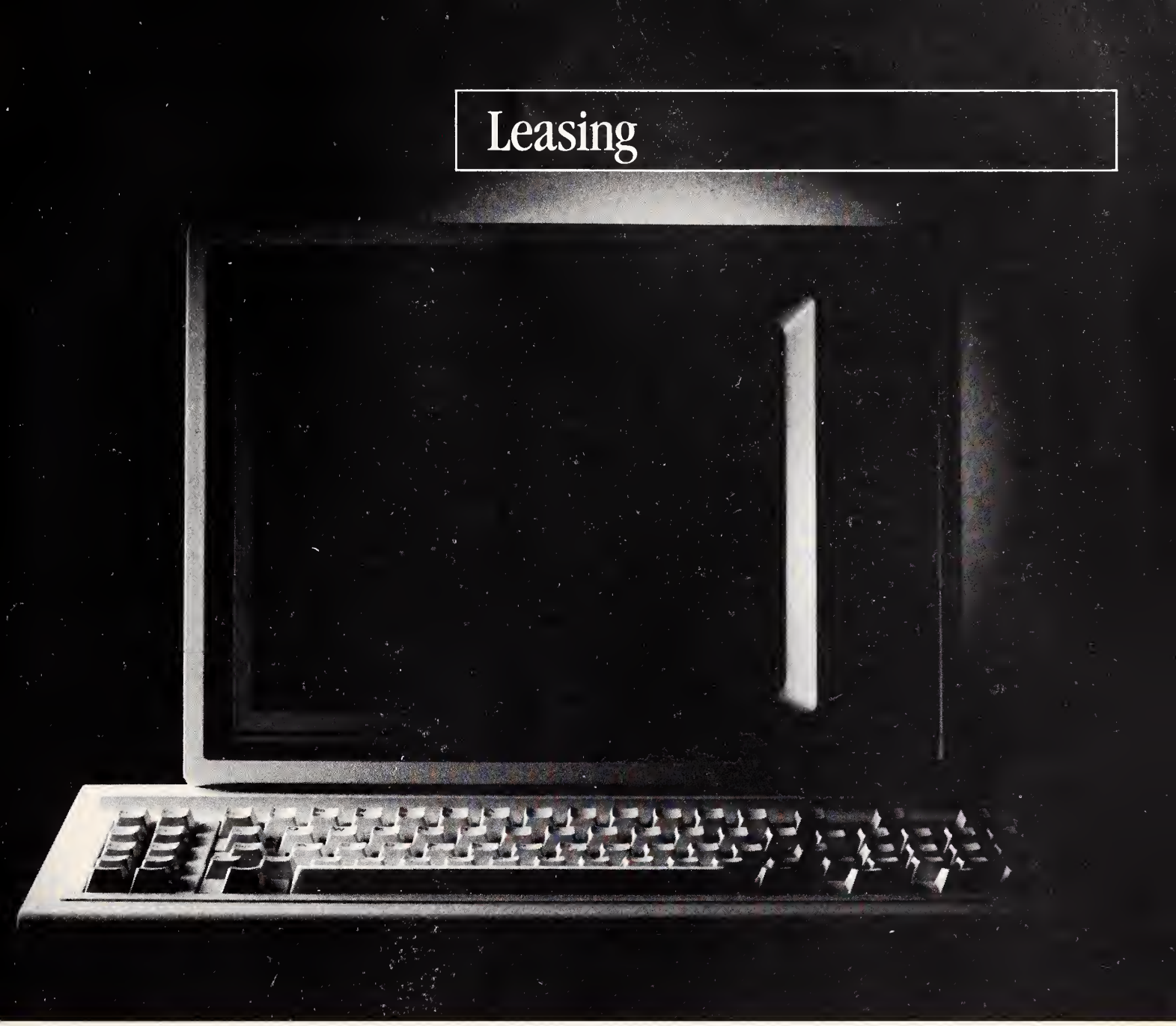
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Landing With Your Wheels Up

(Continued from page 329)

The tort system is an adversary system. Exchanges during the proceedings may become heated at times. The physician should not be taken aback if this occurs and should strive to avoid emotional involvement.

The first instruction from the insurance company or attorney may be not to discuss the case with anyone. These instructions must be put into perspective. The physician should avoid angry remarks to patients, letters to the editor, or similar actions. Discussion with other persons can be inquired about by opposing counsel. Frequently, the issue is pursued in the hope of finding someone who will testify to some admission against interest made by the defendant. On the other hand, communications to a spouse, attorney, or minister are privileged and may not be inquired about.

The physician's deposition will likely be taken. This is an opportunity for opposing counsel to learn the physician's version of the facts of the case. Occasionally, questions will be asked designed to secure admissions from the physician. The physician's attorney will discuss the procedures and what may be expected prior to the deposition. My experience has been that physicians approach a deposition initially with a great deal of apprehension. This usually dissipates quickly after some experience is gained.

Every case must be prepared and researched as if it will be tried. In actuality, 90-95% of the cases filed are not tried, either because of abondonment by the plaintiff, dismissal, or settlement.

The purpose of the liberalized rules of discovery is to encourage settlements and minimize the number of trials. If they are properly used, both sides are able to assess the strengths and weaknesses of the case and realistically evaluate the issues of liability and damages. While professional liability policies no longer contain a requirement that the insured must consent to settlement, as a practical matter the companies are quite interested in the physician's opinions and wishes. Companies, and the attorneys they retain, are experienced in assessing such cases and normally have a more objective view of the merits of the case than does the defendant.

A physician who works with his/her attorney will develop a positive mental attitude about the defense of the case. Talking through the emotional hurt and cooperating in the defense will do much to create a winning position. Juries are impressed by many subjective signs and unspoken communications. If the physician's expectations are realistic, and a concerned, caring, and nondefensive candid attitude is projected, a confident position will be reflected. When these things are accomplished, half the battle is won.



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(Continued from page 315)

medical facilities and physicians is going to be worsened, not helped, unless the contributing base is widened. This most likely will be some type of tax (employer or sales).

All of us have feelings — some very strong — regarding the change from individual responsibility for health costs to a government funded and administered health system for some paid for by all of us. During the 1950s, some warned the rest of us what was likely to happen next, but I would guess no one imagined things would get as bad as they are now.

The purpose of this letter is to call your attention to the similarities then and now. No one in Topeka on September 6, and no one whose opinions I have read, has addressed the direct or indirect effects of tort reform on the individual physician and the private practice of medicine. In my opinion, it would be a mistake to rush into a "tort reform" attitude and — under the guise of lowering malpractice premiums — help produce legislation that could end both the individual right of responsibility and individually practiced private medicne.

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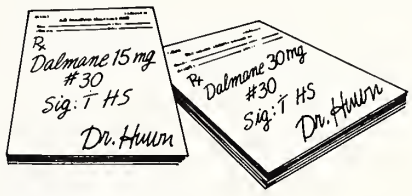
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References: 1. Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



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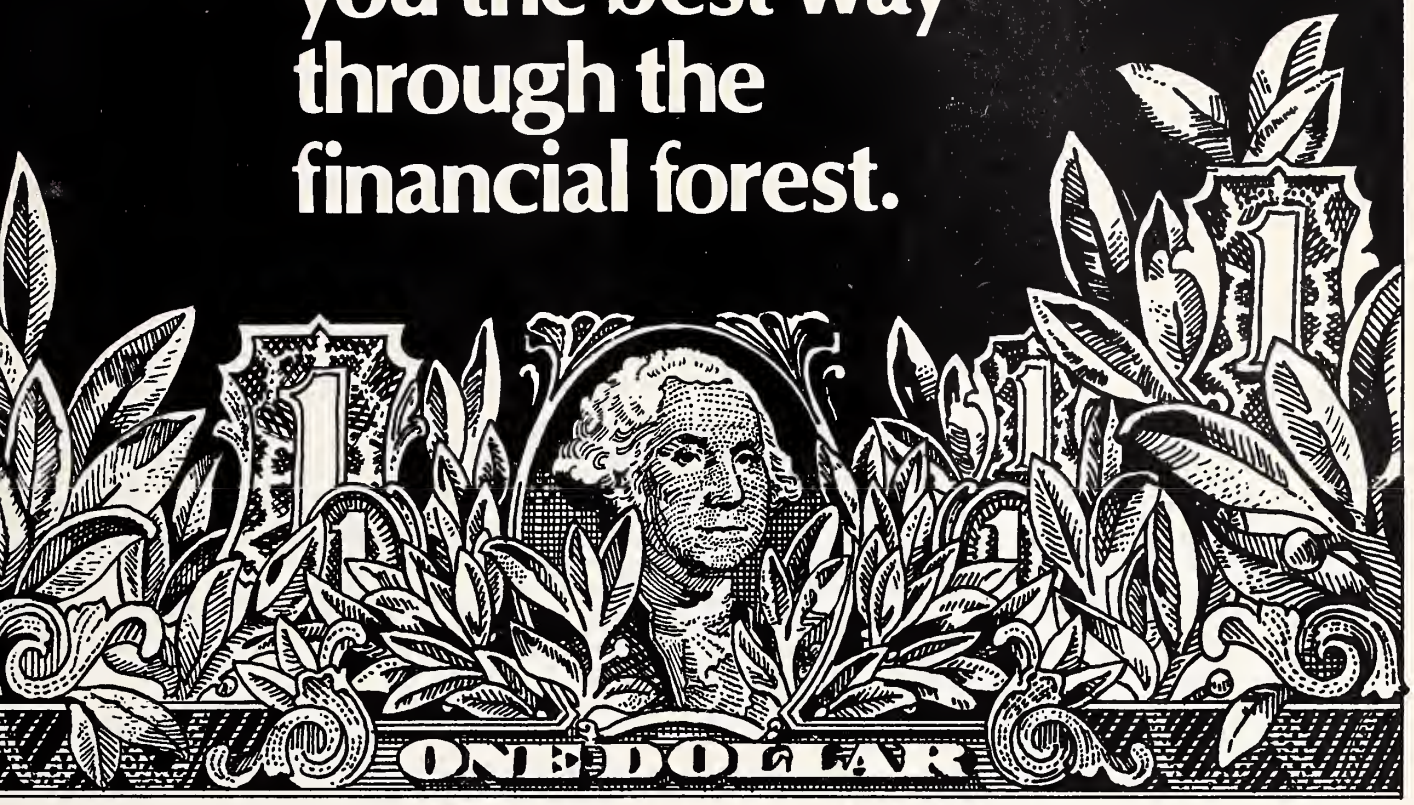
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AMA DELEGATE REPORT

Unified Membership

Editor's note: The 1985 House of Delegates adopted Resolution #85-12 that mandates unified county-state-national membership effective January 1, 1986. This is the sixth in a series of short messages to Kansas physicians presented by members of the Kansas AMA delegation.

The House of Delegates decided in May that Kansas would unify local, state, and AMA membership effective in 1986. Other delegates have discussed various aspects of this decision and what it will mean to each of us.

Professional liability is one of the most difficult and threatening aspects of medical practice. Attempts to develop appropriate solutions must be made at both state and national levels, and my membership in the professional liability committee of the American College of Obstetrics and Gynecology has made me aware of this need. Specialty organizations are helpful, but cannot fill the significant need for an overall umbrella.

The American Medical Association has created a professional liability commission to develop ideas, strategies, and programs. They also have several other departments that help to address the issue. The public relations department has developed excellent materials for use by the states. For instance, the AMA paid for nine airings of a professional liability television spot announcement in the Kansas City area.

I hope you will continue your concerted support of our state activity by joining in our partnership with the AMA.

Jimmie A. Gleason, M.D., Topeka
Alternate AMA Delegate

The Cost Crisis

The headlines are everywhere: "Congress Seeks to Cut Cost of Health Care," "Health Care Costs on the Rise for Most Americans," and so forth. It's progressed to the point where physicians may have to go back to school for accounting degrees in order to keep up with the changing economic realities of medicine.

Indeed, physicians have become quite aware that the cost of health care is more important than ever. A recent American Medical Association survey indicated that physicians see the cost of health care as the number one problem facing medicine. There is no question that physicians are interested in seeking a solution to the cost crisis, although not at the expense of their duty to their patients — a duty based on providing high quality care with access to all.

Nowhere is cost more of an issue than in Washington, D.C. Congress, the executive branch, and federal regulatory agencies are besieged daily by a combination of forces, all with their own agendas for "controlling the spiraling cost" of medical care. Unfortunately, there is not the same level of concern about the *quality* of health care in this country.

In recent years, hundreds of bills and regulations have been drafted in the name of health care cost containment. In the face of such mounting pressures, the government responded by getting more and more involved in legislating reimbursement methods, payment levels, and even access to care.

American health care arrived at this point as a result of a government-backed societal push toward increased quality and access to care. The 50s, 60s, and early 70s were a period of rapid economic expansion in medicine. The goal? Assurance that every American, regardless of race, creed or economic status, would be guaranteed quality health care regardless of the cost.

Was the spending worth it? Did the nation meet its medical objectives? The brief summation of accomplishments below indicates a resounding yes:

- Americans' life expectancy has risen from 69.7 years in 1960 to 74.5 years in 1982;
- Infant mortality has been reduced to a record low of 11.2 per 1,000 live births, less than half the figure in 1960;
- Modern vaccines have been responsible for virtually eradicating polio, mumps, and measles;

• Due to technological advances such as open-heart surgery, pacemakers and new drugs, deaths from heart disease dropped by 25%, and from stroke by 40%.

Clearly, health care American-style is unparalleled elsewhere in the world. Also obvious is the fact that these new procedures and technologies have placed a heavy economic burden on the public and private sectors.

How should this burden be resolved? Who should shoulder the responsibility for the rising costs of care? Certainly physicians, who actually account for only 20% of the rise in health care costs, can do only so much. Physicians, however, can and have taken an active role in trying to reduce the cost of medicine without sacrificing quality through support and involvement in programs sponsored by the American Medical Association.

In 1983, the AMA took advantage of its leadership role by putting forth a bold new agenda to address the problem of rising health care costs and to ensure that quality and access remain the cornerstones of American medicine. The Health Policy Agenda for the American people brings together representatives of about 150 organizations representing a wide range of health care interests.

In 1984, 159 broad-based principles were developed to address issues in six areas: medical science; education; health resources; delivery mechanisms; evaluation; assessment and control; and payment for services. Forty-one final policy proposals, based on these principles, will be published by mid-1986.

In addition, the AMA has encouraged the organization of voluntary coalitions of physicians, hospitals, insurers, and business and labor leaders to seek ways to contain costs at the local or regional level while maintaining accessibility to high quality care.

The AMA was also instrumental in establishing the National Commission on the Cost of Medical Care to seek cost solutions through a variety of means without decreasing the quality of care. Moreover, the Association publishes an annual *Cost-Effectiveness Plan* and the monthly *AMA Cost-Effectiveness Bulletin* that provides a communications network to members of state and county medical societies for cost-effectiveness reporting and information sharing.

The Cost-Effectiveness Network brings together physicians and hospital staffs to experiment with efforts at decreasing cost and increasing medical professionals' awareness of the means to do so. The AMA also sponsors annual conferences on this important topic.

The AMA has strongly opposed the "Kennedy-Gephardt" legislation that would set reimbursement caps on each hospital's total revenues, regardless of payor source. This legislation calls for a radical, untried system of reimbursement and an enormous bureaucracy, and would raise the spectre of rationing of health services.

The AMA also believes that a generally better-informed, healthier public can contribute greatly to the reduction of health care costs. For example, at meetings, members take stands on such topics as the use of air bags in automobiles and labels on cigarette packages. The AMA then communicates these recommendations to the public and health policymakers.

No one segment of the health care system can solve the dilemma of rising medical costs — especially when those costs are reflective of an incredibly sophisticated, effective health care system like the one we enjoy in this country. Physicians, however, through their membership and support of the AMA, can take a leadership position in this effort to intelligently and compassionately control costs without unduly jeopardizing the quality of care that Americans expect and indeed deserve.



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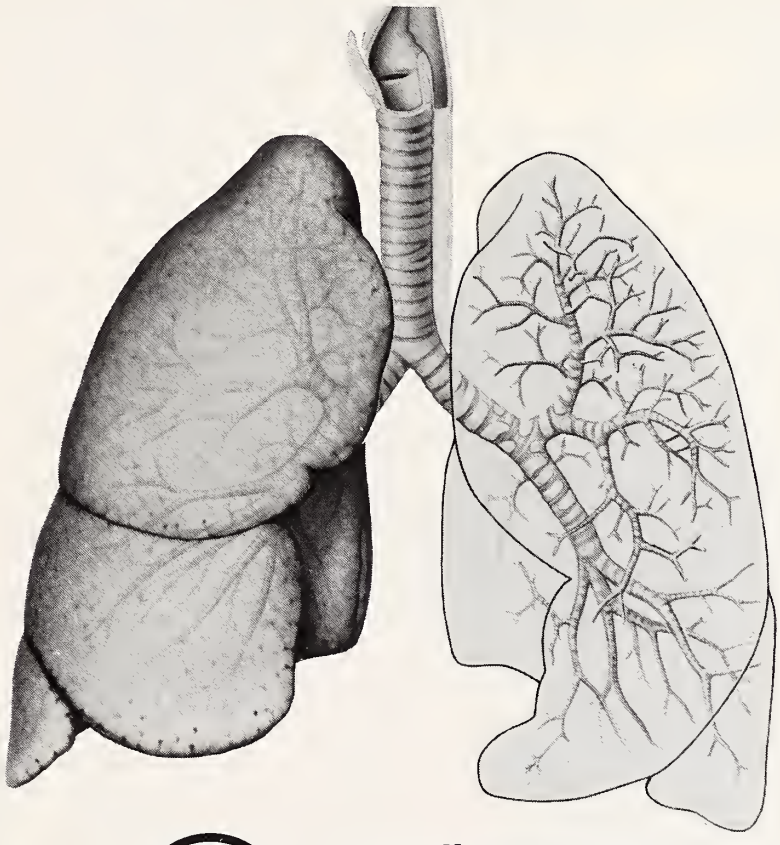
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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

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Note. Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

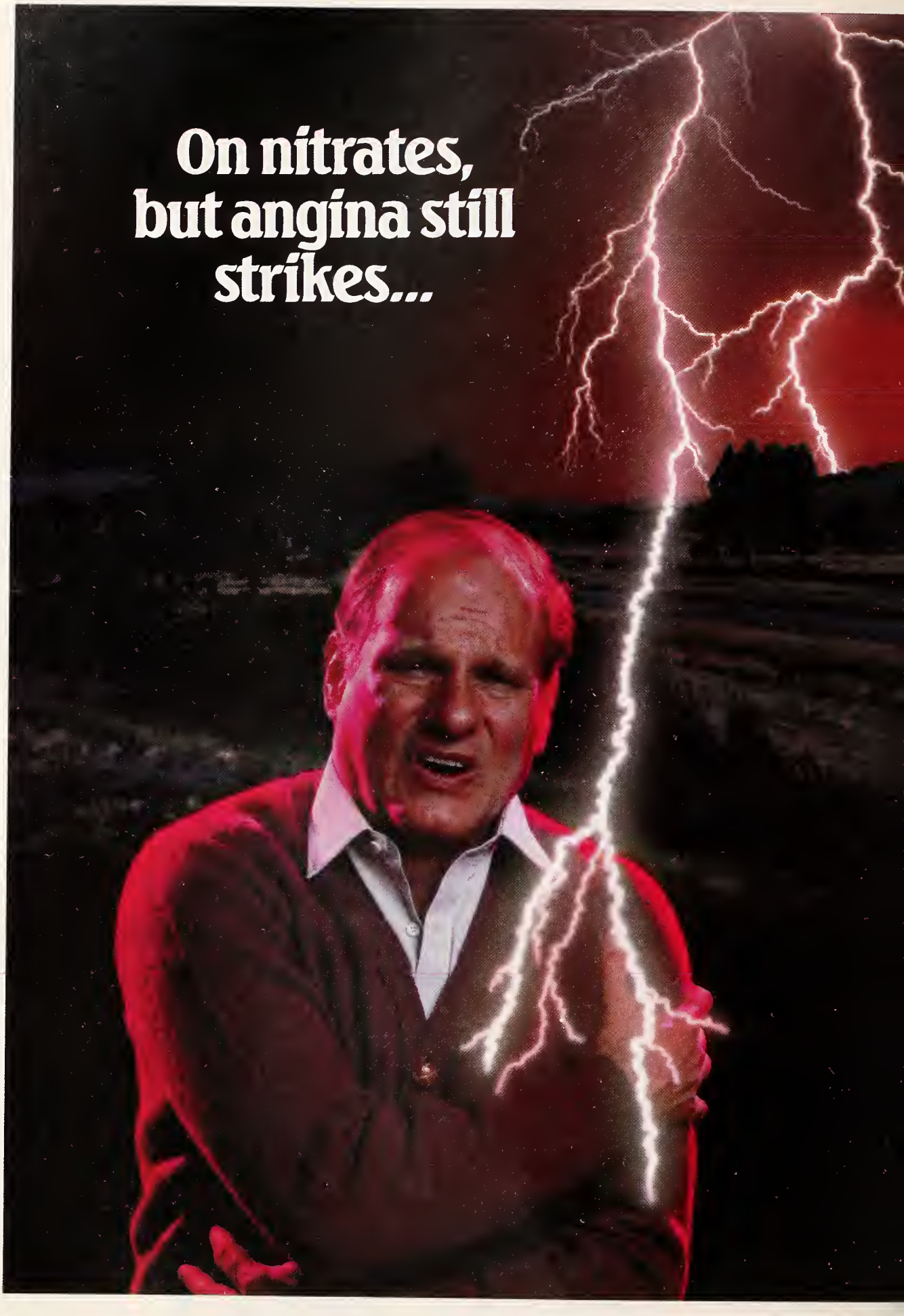
Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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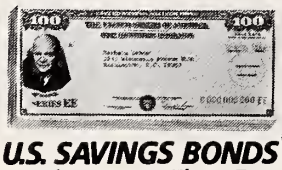


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Motor Vehicle Safety

Emergency physicians are usually the first medical professionals to treat victims of motor vehicle accidents. Frequently they also minister to the families of victims who have died or suffered permanent injury.

In response to this human loss and tragedy witnessed by emergency physicians every day, the American College and Emergency Physicians (ACEP) has adopted the position that traffic safety measures must be mandated and enforced when possible. Safety laws are not an infringement on individual rights; they are a means to reduce the morbidity and mortality rates stemming from motor vehicle accidents, and to permit reallocation of society's resources to more beneficial programs.

The following laws or regulations should be enacted and enforced:

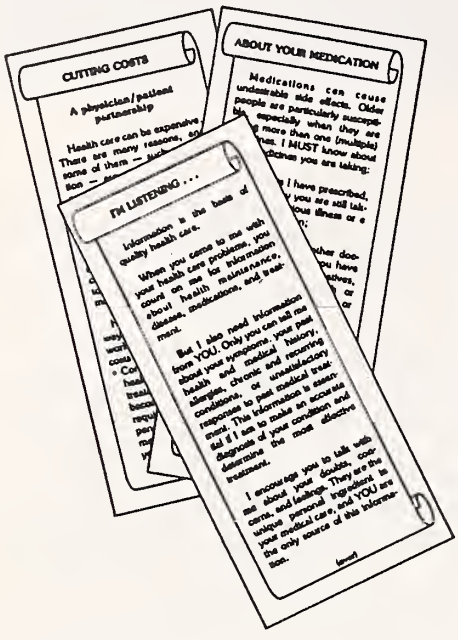
- Require motorcyclists and riders on all other similar vehicles, including but not limited to mopeds, bicycles, snowmobiles, and all-terrain vehicles, to wear helmets.
- Require motor vehicle drivers and passengers to wear seat belts.
- Require passive restraints in all new car models manufactured after September 1, 1989.
- Require that all children under age 4 or under 40 pounds be restrained in approved child restraint seats whenever riding in a motor vehicle.
- Require for drunk drivers a combination of mandatory rehabilitation programs and mandatory legal sanctions, such as suspension of the driver's license or a defined jail sentence.
- Establish a national legal drinking age of 21.
- Support "Dram Shop" laws that establish liability against any person who serves alcoholic beverages to an individual who is visibly intoxicated.
- Prohibit consumption of alcoholic beverages in motor vehicles.
- Prohibit possession of open alcoholic beverage containers in the passenger compartments of motor vehicles.
- Create a dedicated funding source within states and municipalities from DUI offender fines and fees to increase efforts in enforcement, prosecution, adjudication, education and treatment of offenders.
- Establish an "implied consent" statute that provides that all licensed drivers have given their consent to blood, breath, or urine tests that will determine alcohol or drug concentrations.
- Permit police officers to use preliminary breath tests, and permit these tests to be admitted as evidence in DUI trials.
- Require mandatory testing of alcohol and drug levels of all fatally injured drivers and all drivers who are involved in a fatal or serious personal injury crash in which there is probable cause to suspect substance abuse.

ACEP is strongly committed not only to legislation on these issues, but also to the following:

- Public education and awareness programs.
- Education and awareness programs for physicians and other health care professionals.
- Research to determine the causes of automobile accident morbidity and mortality, to identify measures to reduce this morbidity and mortality, and to monitor the effectiveness of public education programs and the impact of legislation.

ACEP encourages its members, as physicians and citizens, to take the lead in motor vehicle safety activities at the local, state, and national levels.





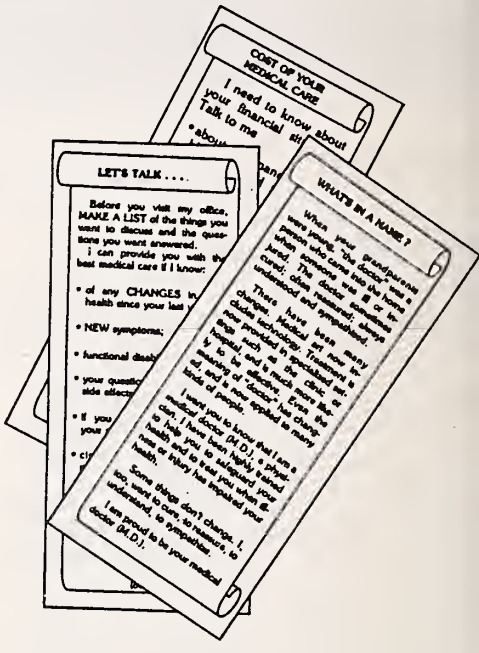
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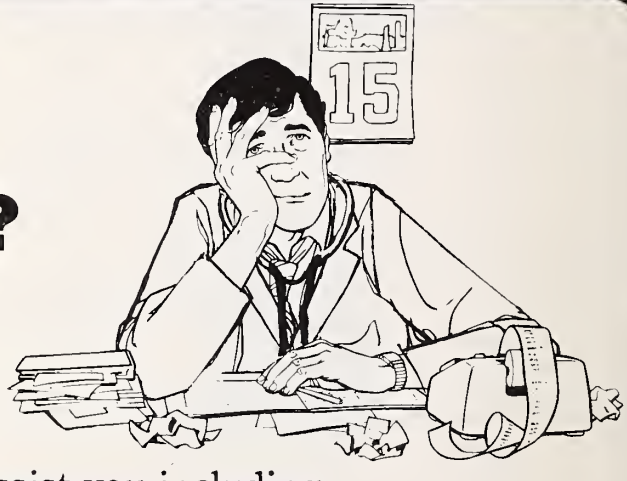
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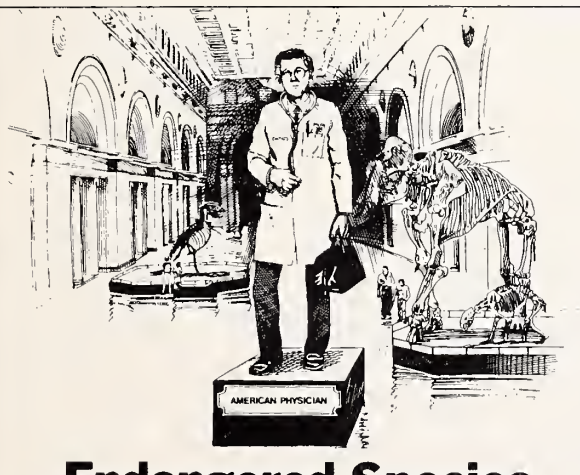
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CONSTITUTION

and

BY-LAWS

Kansas Medical Society

May 1985

ACT OF INCORPORATION

An Act to Incorporate the Kansas Medical Society

Be it enacted by the Governor and Legislative Assembly of the Territory of Kansas:

Section 1

Amory Hunting, S. B. Prentiss, J. P. Root, A. Fuller, C. F. Kobb, J. W. Robinson, J. B. Wheeler, L. C. Tolles, S. C. Harrington, A. Danford, C. E. Minor, J. B. Woodward, W. Madison, J. H. Phelps, O. Brown, Charles Robinson, M. F. Holladay, H. J. Canniff, A. J. Ritchie, M. Baily, J. M. Pelot, H. H. Beals, J. G. Blunt, T. Linsey, G. W. Beaumont, J. Leigh, A. Newman, H. Harttmann, Wm. Graham, and their associates and successors, who shall be elected to membership as hereinafter provided, are hereby constituted a body corporate and politic by the name of the Kansas Medical Society, and shall have perpetual succession forever. Said Society may have a common seal, and change or alter the same at pleasure.

Section 2

That members of said Society, in their corporate capacity, may elect such officers as they shall judge necessary for its government and the management of its affairs, determine the name, power, duty and term of office of each, also the time and manner of said elections.

Section 3

Said Society, by and in their corporate name, may have all the rights, privileges, and powers of a natural person in law and equity.

Section 4

Said Society may elect such persons to membership as they shall judge proper, and shall have power to expel, suspend, or disfranchise the same, as members, from all the rights and privileges of the Society; but such expulsion, suspension, or disfranchisement shall be by a vote of two-thirds of all the members present at a regular meeting of said Society, of which due notice shall have been given.

Section 5

Said Society shall have full power to make and enforce by-laws, and impose and collect at law any reasonable fines, not exceeding fifty dollars, as may be provided in said by-laws, for any and every violation or infraction thereof.

Section 6

Said Society shall issue certificates of membership to all its members, under such regulations as its by-laws may prescribe, and may also grant licenses to all respectable physicians, non-grad-

uates, who shall, on examination, be found qualified for the practice of medicine and surgery, or either, to practice those branches for which they are found qualified.

Section 7

Any three members of said Society may organize county or auxiliary societies in any county of this Territory; and said auxiliary society, when so organized, shall have all the powers and privileges, in the corporate name which they may adopt, that are conferred, by this act upon the Kansas Medical Society; and the officers of said auxiliary societies shall be honorary members of the Kansas Medical Society.

Section 8

A meeting of the corporators, or a part thereof, shall be held in Lawrence, on February 10, A.D., 1859, for the purpose of electing the first officers and completing the organization.

Section 9

This act to take effect and be in force from and after its passage.

C. W. Babcock
President of the Council
Approved February 10, 1859

A. Larzelere
Speaker of the House of Representatives
S. Medary, Governor

CHARTER DECLARED VALID 1881

In 1880 a lawsuit reached the Supreme Court of Kansas contending in part:

"1. That the charter of the Society has expired by statutory limitation;

"2. That the power of the territorial legislature, being permissive and temporary only, could confer no invested right, by contract or otherwise, which would bind the state against its consent;

"3. That the charter of the Society was granted by a territorial act, not accepted or preserved by the state; and

"4. That the legislature did not and has not the power under the constitution to recognize or validate the existence of the Society, nor to grant it additional powers by the act of 1879. . . ."

In the January term, 1881, in the case, STATE OF KANSAS ex rel. v. D. W. Stormont and others, the Supreme Court of the State of Kansas, with all justices concurring, said in part:

"The Society was incorporated, by a special act of the territorial legislature, on the 10th day of February 1859. . . ." *It is,* ". . . hereby constituted a body corporate and politic, by the name of the 'Kansas Medical Society,' and shall have perpetual succession forever. It is conceded that the legislature of the territory had the power to incorporate the Society by a special act. Having the power to create the corporation, it had the further power to endow it with all the attributes of a corporation, not inconsistent with the provisions of the Constitution of the United States, and the act organizing the territory of Kansas, approved May 30, 1854. . . . Therefore, within this definition, immortality is a legitimate attribute to be conferred on a corporation. . . . When not limited or forbidden by constitutional or organic law, the right to confer perpetual succession by legislative authority, so far at least as human agency can confer such an attribute, cannot be logically questioned. . . . This much is clear: The charter did not expire by the law of 1855.

"Our conclusions upon the foregoing matters are that the Kansas Medical Society was lawfully chartered by the territorial legislature; that it was legally endowed with perpetual succession forever; that the constitution did not suspend or repeal its charter; that, if the state legislature has the power to suspend or repeal the charter (which we do not decide) it has never exercised, or attempted to exercise, the power; and that the Society is a lawfully existing corporation."

CONSTITUTION

ARTICLE I — Title and Definition

The name of this organization is THE KANSAS MEDICAL SOCIETY. The SOCIETY is comprised of the Component Societies chartered by this organization.

ARTICLE II — Objects

The object of this SOCIETY is to unite the medical profession of the State of Kansas in promoting the science and art of medicine and protecting the health of the citizens of this State.

ARTICLE III — Component Societies

County or multi-county societies holding a charter from this organization are known as Component Societies.

ARTICLE IV — Members

The KANSAS MEDICAL SOCIETY is composed of members of the Component Societies and others as provided in the By-Laws.

ARTICLE V — House of Delegates

The House of Delegates is the primary legislative and governing body of this SOCIETY. The members of the House of Delegates will be elected by the Component Societies as provided in the By-Laws. This body will transact the business of the SOCIETY and will elect officers except as otherwise provided in the By-Laws.

ARTICLE VI — Officers

The officers of this SOCIETY are a President, a President Elect, a First Vice President, a Second Vice President, a Secretary, a Treasurer, a Speaker and a Vice Speaker of the House, Delegates and Alternate Delegates to the American Medical Association. The terms of office, qualifications, and method of election shall be provided in the By-Laws.

ARTICLE VII — Council Districts and the Council

The boundaries of the Council Districts shall be specified in the By-Laws. The Council consists of one Councilor from each Council District, the officers of the SOCIETY, and advisory members as designated in the By-Laws. The Council may transact business of the SOCIETY between sessions of the House of Delegates subject to the approval of that body and as prescribed in the By-Laws.

ARTICLE VIII — Meetings

The SOCIETY will hold an annual meeting for the presentation and discussion of subjects pertaining to the science and art of medicine. The House of Delegates shall convene at the annual meeting and at other times as necessary for the transaction of the business of the SOCIETY. The place of the annual meeting shall be approved by the House of Delegates, following a recommendation of the Council.

ARTICLE IX — Funds, Dues, Assessments

Funds for the functioning of this SOCIETY shall be raised by an equal annual dues or by assessment of the Members who are subject to these charges as provided in the By-Laws. The amount of dues and assessments shall be determined by the Council and approved by the House of Delegates.

ARTICLE X — Seal

The following insignia shall be the official seal of this SOCIETY:



The official seal shall at all times remain in the custody of the Secretary.

Amendments to Constitution

ARTICLE XI — Amendments

Amendments to this Constitution require an affirmative vote of two-thirds of the Delegates present provided the question has been introduced at the previous annual session, or upon recommendation by the Council and published twice in *The Journal of the Kansas Medical Society,* or submitted by the Council to each Component Society at least two (2) months in advance of the meeting.

BY-LAWS

1.0 MEMBERSHIP

1.1 Each component society shall judge the qualifications and classify its own members. When names are submitted on a properly prepared roster to the state office along with payment of the full annual assessment to the Kansas Medical Society, if required by their classification, the listed physicians shall become members of the Kansas Medical Society, and they shall remain so as long as they are members in good standing in their component societies and the dues to the Kansas Medical Society remain paid, provided that

1.11 Every active member of the Society shall fulfill the requirements of postgraduate medical education set forth by the Commission for Education of the Kansas Medical Society.

1.111 Out of State members shall be exempt from the continuing medical education requirement.

1.2 Before a charter is issued to any component society, ample and full opportunity to become a member shall be given to every physician residing or practicing in the area encompassed by that society.

1.3 Every qualified physician shall be privileged to apply for membership in an established component society encompassing his/her area of practice.

1.4 When a member's practice is interrupted by an authorized absence, his dues will not be refunded except upon recommendation by the component society to which he belongs.

1.5 Members may attend an annual session after first registering and being verified.

1.6 Classification of members

1.61 Members with the right to vote and hold office:

1.611 Members who pay full dues. Members of a component society who hold a degree of Doctor of Medicine, Doctor of Osteopathy, or their equivalent, and are fully licensed to practice medicine and surgery by the Kansas State Board of Healing Arts.

1.6111 Active Members (1st year) — Physicians in their first year of full time medical practice after completing their residency requirements. They shall pay 50% of regular dues and assessments the first full dues year.

1.612 Dues-Exempt Members: Component societies may designate members to be excused from paying dues in these categories:

1.6121 Personal Exemption: Members for whom extended illness or financial limitations create genuine difficulty in paying the dues.

1.6122 Retirement: Members who have retired from active practice. Members in this category may hold an inactive license to practice medicine and surgery.

1.6123 Service: Members temporarily serving with the armed forces except as provided in 1.7.

1.6124 Emeritus: Members over seventy (70) years of age, with dues-paying status for ten (10) years or more may apply for this category, or elect to retain active membership.

1.6125 Probationary Members: Upon certification by the secretary of a component society that a member has been accepted on a probationary basis, the Kansas Medical Society will place his name on the membership rolls. The probationary member will receive the *Journal* and all other correspondence forwarded from the state office. He may serve on committees and commissions but is not eligible to serve as a state or AMA delegate, councilor, or officer. One-half regular dues will be assessed during this period. This category of membership terminates when the component society either votes him into active membership or drops him from their membership rolls.

1.6126 Interns and Residents engaged in full-time training shall be given full privileges of membership including the right to vote and hold office and be assessed annual dues of ten dollars ($10.00).

1.6127 Medical Students shall be given full privileges of membership including the right to vote and hold office, and be assessed no annual dues.

1.62 Members with full privileges except for the right to vote and hold office. They apply for membership through a component society but are assessed less than the full amount of dues:

1.622 Academic Members: Physicians whose activities are predominantly teaching, administration, or research in approved medical schools. Those with a teaching classification below the level of assistant professor shall pay 50% of the regular dues and assessments.

1.623 Associate Members: Physicians who are active members of another state medical society and wish to affiliate with the Kansas Medical Society. They shall pay fifty per cent (50%) of the regular dues and assessments.

1.63 Honorary Members: Persons outside the membership of this Society may be designated Hon-

orary Members by a majority vote of the House of Delegates. They pay no dues and may not vote or hold office:

1.631 Members of the medical societies of other states or of foreign medical societies recognized by the American Medical Association.

1.632 Physicians from Kansas, having graduated from an accredited school of medicine, and who are serving outside the United States as missionaries or in education or philanthropic work.

1.633 Non-physicians, whether Kansans or not, who have made an outstanding contribution to the Kansas Medical Society or to the field of Medicine in general.

1.634 Physicians from the membership of this Society are named for notable achievement in the field of medicine or extraordinary service in the interest of this Society. They are granted Honorary status by a vote of the House of Delegates and pay no dues, but if they were previously voting members, retain the right to vote and hold office.

1.7 Leave of Absence: Leave of absence is granted any member for the period specified by the secretary of his component society, in written certification to the secretary of this Society, excepting that an absence shorter than six (6) months will not alter his previous status. A member on leave of absence for more than six (6) months is exempt from payment of dues in any full six (6) months of absence calculated from 1 January and 1 July, upon certification by his component society.

1.71 Dues will not be exacted from the member on leave at the time they become payable. If he is absent for a full year or more, the prepaid dues will be applied to the year of his return.

1.72 A leave of absence exceeding one year, calculated from the first certification in the annual report of membership, must be recertified in each subsequent annual report, or until notification of reinstatement (or discontinued membership) is received from the component society.

1.8 Dues Refund: Refunds of one half (½) membership dues will be considered on an individual basis upon application to the Executive Committee prior to July 1.

1.81 One-half Year Memberships: One-half year memberships will be considered on an individual basis upon application to the Executive Committee.

2.0 ASSESSMENTS

2.1 The amount of the annual assessment for the Kansas Medical Society only shall be determined by the Council after consideration of the annual budget for the ensuing year and announced to the various component societies not less than sixty (60) days before the beginning of each fiscal year. Such assessments shall be levied against and paid by the component societies in the manner provided by this Constitution and By-Laws, except that any new member of this Society being accepted by a component society after July 1, shall be assessed one-half the annual sum decided upon by the Council, and shall be accorded all the rights and benefits of this Society, including defense, until the succeeding January 1.

2.2 Assessments shall include subscription to the *Journal of the Kansas Medical Society* at a rate determined by the Editorial Board with the approval of the Council.

2.3 Special assessments may be levied as needed. Request for special assessments will be referred to the Council for study, whereupon the Council shall make a recommendation to the House of Delegates for final action. All special assessments are mandatory upon all full dues-paying members unless otherwise specified.

3.0 ANNUAL AND SPECIAL SESSIONS

3.1 The Society shall hold an annual session at the time and place determined by the Council at the preceding annual session. The date and location of the annual session may be changed by the President subject to the approval of the Council. *Provided:* that each component society is notified of the change at least five (5) weeks before the new date.

3.2 Special meetings of the Society may be called by the President upon approval of the Council.

4.0 GENERAL MEETINGS AND SECTIONS

4.1 The Scientific Assembly at the annual sessions may be divided into general meetings and sections by the local Committee on Arrangements with approval of the Committee on State Meeting Format.

4.2 The general meetings and sections of the Society shall be devoted to scientific work together with such reports and announcements as may come from the House of Delegates or the Council.

4.3 The Society reserves the right to publish in the *Journal* any paper read before the Society. The Society also shall be entitled to a copy of the paper if so desired.

4.4 Registration for General and Sectional Meetings. Only the following shall be permitted to regis-

ter and attend:

4.41 Members: Members of the Society who are in good standing.

4.42 Invited Guests: Non-members of the Society may be invited to the general session or sections, but may be excluded by the Executive Committee of the Society or officers of the Sections.

4.43 Residents and Interns: Residents and interns who are graduates of approved medical or osteopathic schools and who are certified by their hospital.

4.44 Medical Students: Medical students of approved medical and osteopathic schools who are certified by their schools.

4.5 The Scientific Assembly

The Scientific Assembly may be divided into sections representing the various specialties in the practice of medicine. Any member of the Society shall be entitled to attend the scientific programs of specialty sections.

4.51 An application for a new section or a request to discontinue a section shall be referred to the Council for study, whereupon the Council shall make a recommendation to the House of Delegates for final action.

4.52 Sections will be governed by their respective officers.

4.53 Officers will consist of a chairman, vice-chairman and secretary-treasurer.

4.54 Terms of office will be for one (1) year and each officer may succeed himself.

4.55 Each section will prepare its own program subject to approval by the Committee on State Meeting Format. Programs must be submitted to the committee far enough in advance to be included in the annual session program.

4.56 Papers and records of proceedings of the sections shall become the property of the Society and filed in the central office of the Society.

4.57 All resolutions and memorials of a general meeting or a section, intended to be issued in the name of the Society, must be approved by the Council or House of Delegates before being issued or becoming effective.

4.58 Each section may enact its own rules of conduct that do not conflict with the Constitution or By-Laws of the Society. Sections approved by the Society include:

4.581 Kansas Society of Anesthesiology

4.582 Section on Ophthalmology

4.5822 Hospital Medical Staff Section

Purpose. The purpose of this section is to provide a direct means to address the relationship between members of the Kansas Medical Society and hospital staffs.

Membership. Membership in the section shall be limited to KMS members selected by physician members of the medical staffs of hospitals.

Governing Councils. There shall be a Governing Council of the Hospital Medical Staff Section to direct the programs and activities of the section, subject to the approval of the KMS Council.

Members. There shall be five voting members of the Governing Council, consisting of the officers, delegate and alternate delegate, elected at the business meeting of the section.

Officers. The officers of the section shall have the following duties and responsibilities.

Chairman. The Chairman shall preside at the business meetings of the section and at meetings of the Governing Council.

Vice Chairman. The Vice Chairman shall assist the Chairman and preside in the absence of the Chairman or at his/her request.

Secretary-Treasurer. The Secretary-Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the members of the section in the KMS House of Delegates.

Term. Governing Council members, including the Delegate and Alternate Delegate, shall serve staggered three-year terms, beginning at the conclusion of the Annual Meeting at which they were elected.

Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Business Meeting. There shall be a business meeting of members of the section held prior to each Annual Meeting of the House of Delegates.

Representatives to the Business Meeting. The physician members of the medical staff of each hospital may select a representative to the business meeting of the Hospital Medical Staff Section. The representative must be a KMS member who is an active voting member of the medical staff with clinical privileges at the hospital.

Representatives to the business meeting shall be elected by and from the active voting members of the medical staff of each hospital.

Representatives to the business meeting shall be properly certified by the President or Secretary of the

medical staff.

Only duly selected representatives to the Hospital Medical Staff Section shall have the right to vote at the business meeting of the section, but the meeting shall be open to any member of the Kansas Medical Society. The meeting shall be conducted pursuant to rules or procedure adopted by the Governing Council of the section and approved by the KMS Council.

Purposes of the Business Meeting. The purposes of the business meeting shall be:

a. To hear such reports as may be appropriate.
b. To consider and vote upon such matters as may properly come before the meeting.
c. To adopt resolutions for submission by the section to the House of Delegates of the Kansas Medical Society.
d. To elect at the business meeting prior to the Annual Meeting of the KMS House of Delegates a Chairman, Vice Chairman, Secretary-Treasurer, Delegate and Alternate Delegate.
e. To conduct such other business as may properly come before the meeting.

4.583 Kansas Chapter, American Society of Internal Medicine

4.584 Kansas Obstetrical Society

4.585 Kansas Orthopedic Society

4.586 Kansas Society of Pathologists

4.587 Kansas Chapter, American Academy of Pediatrics

4.588 Kansas Psychiatric Society

4.589 Kansas Chapter, American College of Radiology

4.5810 Kansas Chapter, American College of Surgeons

4.5811 Kansas Chapter, American Academy of Family Physicians

4.5812 Kansas Allergy Society

4.5813 Kansas Urological Society

4.5814 Section, Otolaryngology-Head and Neck Surgery

4.5815 Kansas Dermatological Society

4.5816 Kansas Neurosurgical Society

4.5817 The Kansas Neurological Society

4.5818 Section on Nuclear Medicine

4.5819 Kansas Chapter, American College of Emergency Room Physicians

4.5820 Resident Physicians Section

4.5821 Medical Student Section

5.0 HOUSE OF DELEGATES

5.01 Introduction and General Powers

The House shall consider and advise on matters of interest to the medical profession and of the public in those important matters wherein it is dependent upon the medical profession and shall advocate all proper medical and health legislation, and the diffusion of popular information in relation thereto.

It shall attend to the scientific work and spirit of this Society, and it shall constantly attempt to improve the quality of health care in this state.

The House of Delegates is the ultimate authority in legislative and business affairs of this Society. It may appoint committees from its own members or from members of the Society. Such committees shall report to the House, and may be present and participate in the debates on their reports.

The House may delegate and empower the Council or a special standing committee to employ, advise and supervise an Executive Director whose duties shall be as provided in these By-Laws.

The House shall review the annual budget submitted by the Council and shall make annual appropriations for the expenditures of this Society. It may amend current appropriations at any meeting.

A summary of the proceedings of the House of Delegates shall be published following each annual session in the *Journal of the Kansas Medical Society*.

5.1 Composition

The House of Delegates shall be composed of delegates selected by the component societies, by the elected councilors and in their absence, their alternates, by the recognized sections, the past presidents, and the elected officers of this Society. Members of the Society may attend plenary sessions and others may attend upon invitation of the Speaker.

5.2 Apportionment

5.21 Component Societies: Each component society having made its annual report and paid its assessments as provided in this Constitution and By-Laws shall elect one (1) delegate and one (1) alternate to the House of Delegates for each twenty (20) members and major fraction thereof. Each component single county society shall be entitled to at least one (1) delegate and one (1) alternate, and provided that component multicounty societies have fewer than seventy-five (75) members are entitled to elect one (1) delegate and one (1) alternate, *plus* one (1) delegate and one (1) alternate for each ten (10) members and major fraction.

Student and resident members shall not be counted for the purposes of determining the number of delegates.

5.22 Organized Specialties: Each organized spe-

cialty section recognized by the Society shall be entitled to one (1) delegate and one (1) alternate to be chosen by the section.

5.23 Listing Names: It is the duty of the secretary of each component society and specialty section to send the names of the delegate(s) and alternate(s) to the Executive Director at least sixty (60) days prior to each session.

5.24 Each district councilor shall be a member of the House of Delegates during his Council tenure and in addition to the authorized number of delegates from his component society.

5.3 Delegates

5.31 Qualifications

5.311 Delegates: Each delegate must be a member in good standing of this Society.

5.312 Alternates: An alternate to each delegate shall be elected to substitute for that delegate. Each alternate must be a member in good standing of the Society.

5.313 Substitute Alternate: The House may elect by majority vote a substitute alternate to serve as a delegate for that meeting for a component society which has no delegate or alternate present.

5.314 Proxies: No proxies are recognized.

5.32 Term

5.321 Length: Each delegate and alternate is elected for one (1) year and shall assume office at the first session of the House succeeding his selection.

5.322 Vote: Each delegate is entitled to one (1) vote.

5.33 Registration

All persons attending a session of the House shall register prior to their admission. These registrations are certified by the Committee on Credentials.

5.4 Procedure

5.41 Order of Business

5.411 First Session: The order of business of the first session of the House, unless otherwise ordered by a two-thirds vote of the delegates present, shall be:

5.4111 Registration of delegates, Society members and visitors.

5.4112 Call to order by the Speaker.

5.4113 Announcement of number of delegates present and registered and the presence of an official quorum.

5.4114 Reading of the minutes of last and any special meeting.

5.4115 The report of the nominating committee is read, after which nominations are made from the floor for the office of President Elect, First Vice President, Second Vice President, Speaker, Vice Speaker, Secretary, Treasurer, AMA Delegate and AMA Alternate Delegate, and a ballot vote where three or more candidates have been nominated for one office so that the election at the second session of the House shall present not more than two (2) candidates for each office.

5.4116 Report of the Constitutional Secretary shall be distributed to all persons in attendance. The Constitutional Secretary shall call attention of the House to any statistics relating to membership that are of exceptional importance.

5.4117 The report of the Treasurer, including a proposed budget for the coming year, shall be distributed to all persons present. The Treasurer shall call attention to any specific financial items that are exceptional. The House shall immediately thereafter act to approve the report of the Treasurer.

5.4118 The report of the Editor of the *Journal* shall be prepared and distributed to all persons present.

5.4119 The Speaker of the House of Delegates may invite such persons to present written or oral reports to the House of Delegates which in his judgment will be important for information to the House.

5.41110 The report of the Executive Director shall be prepared and distributed to all persons present.

5.41111 Unfinished business.

5.41112 Reports and presentation of resolutions from Commissions.

5.41113 New business and the introduction of resolutions from component societies, specialty societies, and delegates.

5.41114 Announcements — to include: (1) members of each reference committee; (2) time and place of reference committee meetings; (3) names and districts of expiring councilor and alternate terms; (4) results of primary election; (5) other.

5.41115 Adjournment to reconvene at second meeting.

5.412 Second Session: The official order of business for the second meeting of the House of each annual session shall be:

5.4121 Registration and seating of delegates, Society members and visitors.

5.4122 Call to order by the Speaker.

5.4123 Announcement of number of delegates, the presence of an official quorum.

5.4124 Election of officers (by ballot)

5.4125 Report of reference committees.

5.4126 Unfinished business.

5.4127 New business (this requires consent of a two-thirds majority of delegates present).

5.4128 The Speaker announces the President Elect is now President. The President is invited to present to the House an outline of his plans for the coming year at the time he assumes office. The President then announces the councilors and alternates elected and meeting place of the Council.

5.4129 Installation by the President of the new Speaker and Vice Speaker.

5.41210 Adjournment

5.413 Special Session: The official order of business for a special session of the House shall be:

5.4131 Registration of delegates, Society members and visitors.

5.4132 Call to order by the Speaker.

5.4133 Announcement of number of delegates present and the presence of a quorum.

5.4134 Announcement of business for which session was convened.

5.4135 Report of the commission chairmen and officers pertinent to the subjects for which the special session is convened.

5.4136 Assignment of resolutions to reference committees.

5.4137 Adjournment of the First Session.

5.4138 Second Session — Call to order by the Speaker.

5.4139 Report of the Reference committees.

5.41310 Announcements.

5.41311 Adjournment.

5.42 Privilege of the Floor

The House of Delegates by a two-thirds vote of those present may invite any person to address the House.

5.43 Introduction of Resolutions:

Reports and resolutions for consideration of the House shall be sent to the Executive Office at least six (6) weeks before the date of the annual session. Resolutions or amendments introduced on the floor of the House must be submitted to the Speaker in writing at the time of introduction.

5.44 Process of Resolutions:

5.441 First Session

5.4411 At the first session of the House, all business shall be introduced by title, and referred without debate or action to a reference committee, except as otherwise stipulated in these By-Laws.

5.4412 Resolutions not previously published and distributed to the members of the House shall be read in full.

5.4413 As each resolution is introduced, the Speaker shall designate it with a number.

5.442 Second Session

5.4421 At the second session, the House will receive the report of each reference committee on all business referred to it.

5.44211 If, in the opinion of the reference committee chairman, a resolution can be acted upon without additional discussion, he shall direct the resolution to be placed on the consent calendar. A list of such resolutions shall be presented at the end of the reference committee report. The Speaker shall ask if there is any objection. If an objection appears to any resolution, it shall be removed from the consent calendar and placed before the House for individual consideration. If no objection appears, the resolutions on the consent calendar will be placed as a package before the House for action.

5.4422 Each item of business so reported upon shall be subject to debate and amendment prior to final action.

5.4423 No new business may be considered at the second session of the House except as provided in the By-Laws.

5.4424 If a reference committee fails to submit a report at the second session of the House upon any resolution referred to it, such resolution may be placed before the House by the Speaker and must be so placed upon request of any member.

5.443 Special Session

Resolutions may be considered by the House acting as a whole or by a reference committee prior to action by the House.

5.444 Expiration

Official policies established through resolutions at the House of Delegates shall be in effect for a period of five (5) years, at which time that policy position will be reviewed by the Executive Committee and will expire subject to the approval by the House of Delegates unless superseded or continued by another resolution.

5.45 Quorum

Thirty-five per cent (35%) of constitutionally provided delegates or their respective alternates shall constitute a quorum of the House of Delegates at any regular or special meeting.

5.5 Sessions of the House of Delegates

5.51 Location: The time and place shall be determined by the Council. Notice of annual meetings shall be sent to each component society prior to January 1 of the year the meeting is to be held and shall state the time and place of the meeting.

5.52 Invitation From Component Societies: The Council shall, not later than October, consider invitations received from component societies to serve as host to the annual session for the fifth year following and shall select the meeting place and the date. Should invitations not be received, the Council shall select a meeting place.

5.53 Regular: The House of Delegates shall conduct two meetings, separated by at least twenty-four (24) hours, during each annual session. These may be adjourned and reconvened as necessary.

5.54 Special: Special sessions shall be called by the Speaker as requested by the President upon approval of the Council or the Executive Committee. Special sessions shall be called by the Speaker upon the written request of twenty-five per cent (25%) of the delegates from component societies. When a special meeting is called, the Executive Director shall notify each component society at least twenty (20) days before the meeting date. The notice shall specify the time and place of meeting and the purpose for which it is called.

5.6 Meetings

5.61 Plenary: The House may conduct a meeting to which any person may be admitted. By majority vote of the delegates present, a plenary meeting may become a closed or executive meeting.

5.62 Closed: A closed meeting is restricted to members of this Society and to members of the staff.

5.63 Executive: An executive meeting is limited to delegates and to such employees of this Society necessary for the functioning of the House.

5.7 Designation

The Credentials Committee and the Reference Committee are regularly appointed committees of the House of Delegates.

5.8 Membership

5.81 The Credentials Committee shall consist of three (3) members from separate Council districts appointed by the Speaker for a term of one (1) session. The Speaker shall designate the chairman.

5.82 Each Reference Committee shall consist of not less than three (3) nor more than seven (7) members of the House appointed by the Speaker. The Speaker shall designate the chairman.

5.9 Duties

5.91 Credentials Committee

5.911 The Credentials Committee shall examine the credentials of all who seek admission to the House, and rule on the seating of all delegates. Any member of the Society registered for the annual meeting may be admitted to the visitors' section.

5.912 An individual whose credentials are questioned may appeal to the House immediately following the report of the Credentials Committee that a quorum exists and the issue may be decided at that time.

5.913 The Speaker shall appoint a Sergeant-at-Arms.

5.914 The Credentials Committee shall report to the House upon request of the Speaker on:

5.9141 Total number of members of the House eligible to vote.

5.9142 Number of members registered and seated.

5.9143 Announcement of quorum.

5.92 Reference Committees

5.921 The Reference Committees are appointed for a session of House to consider resolutions referred to them.

5.922 The duties of the Reference Committees shall be:

5.9221 To hold open hearings on all referred resolutions at a time and place announced at the first session of the House.

5.9222 To deliberate in closed session on each resolution, and after consideration recommend its final disposition.

5.923 A member of a reference committee who wishes to make a minority report must refrain from signing the majority report and must make his intentions known to the other members of the reference committee while it is in closed session and prior to the presentation of the majority report to the House.

5.93 Other Committees

The Speaker may appoint such other committees as are needed.

6.0 ELECTED OFFICERS

6.1 Designations

The elected officers of the Society are those specified in Article VI of the Constitution. No member shall hold two elected offices in this Society at one time excepting delegates and alternate delegates to the American Medical Association, who may be elected and serve during a concomitant tenure in another elective office of this Society.

6.2 Qualifications

An elected officer must have been for at least two (2) years immediately prior to his election, an active member of the Kansas Medical Society. The Speaker and Vice Speaker of the House shall be elected from among the members of the House.

6.3 Terms

6.31 President Elect

The President Elect shall be elected annually. He shall serve until the next inaugural after his election when he becomes President.

6.32 First Vice President, Second Vice President, Speaker, Vice Speaker, Secretary and Treasurer.

The First Vice President, Second Vice President, Speaker, Vice Speaker, Secretary and Treasurer shall be elected annually, each to serve for one (1) year or until a successor is elected and installed.

6.33 AMA Delegates

Representatives to the House of Delegates of the American Medical Association shall be elected for two-year terms of office which terms shall not expire in the same year. The term of the delegate-elect and alternate delegate-elect shall begin at the annual session of the American Medical Association the year succeeding their election.

6.4 Presidential Succession

If the Presidency is vacated by reason of death, disability for the unexpired term, resignation, or impeachment and conviction, the line of succession shall be the President Elect, the First Vice President, the Second Vice President, the Speaker and the Vice Speaker.

6.41 If the disability of a president is contested, it shall be determined by a two-thirds concurrence of the Council.

6.5 Interim Vacancies

Should vacancies occur in the office of Secretary or Treasurer, the Council shall fill these positions as provided in the By-Laws.

6.6 Nominations

The Council shall annually at the conclusion of the annual session select three (3) physicians who are members of this Society, each representing a different council district other than the districts of the two (2) recent living past presidents to comprise the nominating committee. The Council shall name a chairman. The committee shall meet not later than ninety (90) days prior to the next annual session and present for publication in the *Journal* a list of candidates for each elective office consisting of one or more candidates for the offices of President Elect, First Vice President, Secretary, Treasurer, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, one (1) or more candidates for the office of delegate-elect and alternate delegate-elect to the American Medical Association, and three (3) or more candidates for the office of Second Vice President. The candidates for Treasurer should be named from residents of the vicinity of the central office whenever possible.

6.7 Elections

6.71 Time: The election of officers shall be held at the last meeting of the House of Delegates at each annual session. During the first session nominations for each office are made. When more than two (2) candidates are nominated for any office, a primary election shall be held at the first House of Delegates meeting. The name receiving the fewest votes shall be eliminated and balloting shall continue until not more than two (2) remain. Tellers shall announce in alphabetical order the names of the two who receive the largest number of votes for each office. In case there exists a tie for second place, another ballot shall be held to select a second candidate. At the last House of Delegates meeting each authorized delegate shall cast his ballot at the time he registers to attend the meeting, and this will constitute the election. In case of a tie, the Speaker, who does not vote otherwise, shall cast the deciding vote.

6.72 Method: All elections of officers shall be by ballot.

6.8 Installation of the Elected Officers

Elected officers, except delegates and alternate delegates to the American Medical Association House of Delegates, shall be installed prior to adjournment of the House at the annual session and shall begin their term of office at the conclusion of the annual session.

6.9 Installation of the President

The oath of office shall be administered to the President Elect during the President's Banquet and/or reception at the annual session. The President Elect shall become President at the conclusion of the business of the House at the annual session.

6.10 Officials impeached

Officials impeached by the Council are tried by the House of Delegates. A two-thirds vote is necessary for conviction.

7.0 DUTIES OF OFFICERS

7.1 President

The President is the chief executive officer and principal spokesman of the Society. He shall counsel

KMS
KANSAS MEDICAL SOCIETY
Newsletter
1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383
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MALPRACTICE UPDATE INTERIM COMMITTEE RECOMMENDS CAPS

The Legislature's Special Interim Committee on Medical Malpractice has issued its final recommendations. They include all of the key elements of the KMS program:

Award Limits. A $250,000 cap on pain and suffering, with a total cap of $1 million on all damages.

Screening Panels. The findings of medical screening panels would be admissible in court.

Peer Review and Quality Assurance. A formalized link between the Healing Arts Board, hospital medical staff committees, and medical society peer review activities would be established. The result would be more timely reports of disciplinary proceedings and protection for members of such committees.

There are about twenty separate recommendations which have been incorporated into one bill. The full legislature will probably begin hearings on the bill early in February. A complete summary of the bill will be sent to all KMS members in the near future.

The Interim Committee vote on the key issues such as award limits basically fell along party lines, with Republicans for and Democrats against. Those voting for the key parts of the bill were: Sen. Robert Talkington, R-Iola; Sen. Jack Walker, R-Overland Park; Sen. Roy Ehrlich, R-Hoisington; Sen. Frank Gaines, D-Augusta; Sen. Jeanne Hoferer, R-Topeka; Sen. Eric Yost, R-Wichita; Rep. Frank Buehler, R-Claflin; Rep. Rex Hoy, R-Shawnee Mission; Rep. Mike O'Neal, R-Hutchinson; Rep. Vincent Snowbarger, R-Olathe; Rep. Dale Sprague, R-McPherson; and Rep. Tom Walker, R-Newton. The Chairman of the committee, Rep. Joe Knopp, R-Manhattan, did not vote, customary except in cases of a tie.

Opposition to the key parts of the bill, specifically award limitations was led by: Rep. John Solbach, D-Lawrence and Rep. Marvin Barkis, D-Louisburg. Others opposed were: Sen. Paul Feleciano, D-Wichita; Sen. Nancy Parrish, D-Topeka; Sen. Jack Steineger, D-Kansas City; Rep. Bill Brady, D-Parsons; and Rep. Ruth Luzzati, D-Wichita.

The Kansas Trial Lawyers Association remained steadfastly opposed to any of the key tort reform issues throughout the Interim Committee's deliberations. As expected, the Kansas Bar Association stood behind the KTLA position and lobbied against all key tort reform issues. KMS had hoped that the Kansas Bar Association would have taken a more moderate position, since it represents all lawyers, including defense lawyers. A fundamental problem is that there aren't any incentives for lawyers to support change of the obsolete legal rules that perpetuate the sprawling malpractice litigation system.

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SRS CRISIS

SRS is facing a financial crisis in FY 1986. The Department of Social and Rehabilitation Services' budget request will reflect "the deepest proposed cuts in a quarter century," according to Secretary Robert Harder, who noted that the cuts result from the state's strained financial circumstances. Without a tax increase, it is unlikely that SRS will be able to adequately fund health care for the Medicaid population.

PRACTICE ALTERED BY INSURANCE?

During the past several months the KMS office has become aware of an increased number of physicians throughout the state who have altered their practices in some way due to escalated malpractice insurance premiums. To aid legislative efforts, a profile is being developed which will indicate the number and extent of modifications being made by Kansas physicians and their impact on the future medical care of Kansas citizens.

To date several names have been received and verified; however there are undoubtedly many more whose names have not come to the attention of KMS staff. If you are aware of physicians who may fit into the profile, please relay the names to the KMS office at 1-800-332-0156. Your assistance in this compilation will lend strong support and substantiation to our legislative message.

MEDICARE FREEZE EXTENSION

As the Newsletter goes to press, Congress has not finalized the Medicare reimbursement provisions. Three congressional committees have recommended changes in Medicare physicians' fees. Extension of the freeze reduces Medicare spending in fiscal 1986 by $55 million. Extension of the October 1 freeze did not affect Kansas physicians who were already enrolled. They were automatically continued unless they had informed Blue Cross/Blue Shield of Kansas, the State's fiscal intermediary for Medicare, in writing, that they did not wish to participate during the next period. Kansas ranked second highest in the nation in the number of participating physicians. KMS is closely monitoring the issue of Medicare fee freeze. Details of any action will be sent to you just as soon as decisions are made.

MEDICARE ASSIGNMENT: Physician Licensure

Massachusetts has enacted a law stating that as a condition of granting or renewing a license to practice medicine, a physician who agrees to treat a Medicare beneficiary must also agree not to charge or collect from such beneficiary any amount in excess of the Medicare determined fee for that service. The constitutionality of the law is being challenged in a lawsuit recently filed by the Massachusetts Medical Society and the Americn Medical Association.

UNIFIED MEMBERSHIP

The state medical organizations of Virginia and Vermont have joined the ranks of those who have unified membership with the AMA. This brings to five the total that have made that decision this year. The others, in addition to Kansas, are Mississippi and Utah. The issue is under consideration in a number of other states, including Missouri. Oklahoma and Illinois have been unified for many years.

LEGAL HOTLINE: 1-800-332-0248

To help members to cope with the increasing legal complexities of health care delivery, the Kansas Medical Society has arranged for the installation of an incoming WATS line to the office of Wayne Stratton, KMS legal counsel. Members may use this line on the following basis:

- Inquiries will be directed to a person in the office who can best respond.
- Brief answers will be made by phone or letter at no charge to the caller.
- If the matter requires more than ½ hour of legal service, the member will be advised that he/she will be billed.

If you have questions about the legal hotline service, contact the KMS office.

A new section, Medicina et Lex has been added to KANSAS MEDICINE. The column deals with subjects of legal interest to physicians. (In this issue, see page 367.)

PHYSICIAN IMAGE

Medicine has evolved from "the caring profession" to "the curing profession," according to medical ethicist Morris B. Abram. Abram, vice chairman of the US Commission on Civil Rights, recently addressed the AMA National Communications Workshop in Chicago. He stated that physicians must return to demonstrating their desire to care and to heal. He noted that a position of esteem is dependent on partnership with the patient, and physicians must take advantage of their numerous patient contacts to reinforce a positive image.

MEEK NEW IM CHAIRMAN AT UKSM-WICHITA

Joseph C. Meek, M.D., has been appointed chairman of the Department of Internal Medicine at UKSM-Wichita. He has been a professor of medicine at UKSM-KC, and holds the positions of Vice Chancellor of Academic Affairs and Director of Health Care Outreach and Continuing Education at the medical school.

SAVINGS ON KMS WORKER'S COMPENSATION PROGRAM

Participants in the KMS Worker's Compensation Program realized a savings on premiums of 27.7% this year, the 8th consecutive year for such savings. Policies written receive a 15% up-front discount as well as additional savings realized on experience ratings of the group. The program is underwritten by Casualty Reciprocal Exchange, Kansas City, Missouri.

MOTORCYCLE ACCIDENTS COSTLY

Orthopaedic injuries sustained in motorcycle accidents cost an average of $17,704, according to a study by Timothy Bray, M.D., and colleagues from the University of California, Davis. They reviewed 51 serial admissions, and found that more than one-half of the patients were intoxicated on admission, that 75% carried no insurance, and that 72% of the cost was paid by the state. "Care of motorcycle trauma consumes a substantial portion of public health care funds in California," they observe. The report appears in the November 1st issue of JAMA.

WOMEN IN MEDICINE RESOURCE PACKET

Information on specialty choices, age, distribution, location by state, and more, of male and female physicians is available in the new resource packet developed by the AMA Women in Medicine Project. The 64-page document, "In the Marketplace," is available from AMA Women in Medicine Project, 535 No. Dearborn, Chicago IL 60610.

MARKET AREA PROFILE SERVICE FROM AMA

The AMA has introduced a new service--the Market Area Profile (MAP) Service. It is designed to assist physicians with medical practice site selection and development by providing them with demographic and health resource data for any area of the United States. For further information, contact the AMA MAP Service, 535 No. Dearborn, Chicago IL 60610, or call 312-645-4719.

ATTENTION: SPECIALTY SOCIETIES

Now is the time to make your comments known if you have concerns that require legislative action. If you have an issue that you would like the KMS to consider or endorse, please submit it to KMS immediately. The KMS Executive Committee will determine KMS policy on the issue. Once policy is established, the KMS Legislative Committee will direct the Society's lobbying activities to achieve the desired legislative goals.

VICTORY FOR AMA

The House Energy and Commerce Committee has voted 22-19 to sunset the health planning act. The provision adopted by the committee would provide that the federal health planning act will expire on September 30, 1986.

The Committee's action marks a major victory for the American Medical Assocation, which has been actively lobbying against reauthorization of the planning act. The AMA has opposed the law since its enactment in 1975, preferring a voluntary local health planning approach.

MEDICAL RECORDS FOR MEDICAID CLIENTS

The New York Supreme Court recently ruled that a physician's failure to keep adequate records for Medicaid recipients could result in disqualification from the program. Records must fully disclose the extent of care, services provided, or supplies furnished to Medicaid recipients. The ruling applies even though the court found no intent to defraud the agency. Kansas physicians who treat Medicaid recipients need to be aware of the serious ramifications of this decision.

AMA PUBLICATIONS

The AMA offers a wide variety of professional publications. Single copies of most of them are available to members at a 10% discount. If you are interested in a specific book or pamphlet, or if you need more information about what is available, contact the KMS office at 1-800-332-0156 (in Topeka, call 235-2383).

with officers, and others, toward the best interests of the public and this Society, to attempt to further the aims and activities of this Society to the fullest extent. He shall perform such services as custom, necessity and parliamentary procedure require. He shall in accordance with these By-Laws announce his appointments to commissions. He shall be an ex-officio member of all committees and commissions. He shall be extended an opportunity to preside at all major functions of the annual session and shall deliver an address at the time arranged by the Committee on Arrangements. He shall be encouraged to visit the various Council districts during his term of office.

7.2 President Elect

The President Elect shall familiarize himself with the personnel and work of the various committees and of this Society in general. He shall be ready to counsel with the President on matters affecting the future of this Society, and shall otherwise prepare himself for assuming the leadership of this Society at the proper time. Except as is otherwise provided in the By-Laws, he shall appoint a chairman and other members of each commission, and other temporary committees, to serve during his term as President. The complete list of appointments to commissions shall be available for publication and distribution to the membership when he assumes the office of President. The President Elect shall assume the Presidency in the event of the death of the President or the inability of the President to perform the duties of the office. In the event of such succession to office, the President Elect shall not be disqualified from serving his term as President for which he was duly elected.

7.3 First Vice President

The First Vice President shall assist the President in the performance of his duties, shall preside in his absence at the meetings of this Society, or the Council, and shall represent the President in his absence.

7.4 Second Vice President

The Second Vice President shall also assist the President in the performance of his duties.

7.5 Speaker

The House of Delegates shall annually elect from its membership a Speaker and a Vice Speaker whose terms of office begin upon adjournment of the last session of the House and continue through adjournment of the last session at the next annual session. They are eligible for succession.

The Speaker is the presiding officer over all sessions of the House. It is his duty, upon consultation with the Vice Speaker, to appoint reference committees. He shall refer resolutions to reference committees and shall aid delegates and committees to the extent of his ability toward the end that all business of the House may be conducted in an efficient manner.

7.6 Vice Speaker

In the absence of the Speaker or at his pleasure, the Vice Speaker will preside over the House and will perform such duties as would otherwise be performed by the Speaker.

At the first session of the House, nominations shall be placed for the office of Speaker and for the office of Vice Speaker. In the event there are more than two (2) nominations for either office, a primary ballot shall be taken and the names of the two (2) receiving the largest number of votes will appear on the ballot at the last session of the House where the election shall take place.

7.7 Secretary

The Secretary shall advise the Executive Director in all secretarial matters of this Society and shall act as the corporate secretary for the executive of official documents. He shall perform such duties as are placed upon him by this Constitution and By-Laws, and in the event of death, resignation or removal of the Executive Director, shall assume the duties of that office until the vacancy is filled.

7.8 Treasurer

The Treasurer shall be the custodian of all moneys, securities and valuable papers of this Society. He shall deposit them in safe banking institutions, or invest them, subject to the direction of the Council. He shall be bonded at the expense of this Society in such amount as the House may require. He shall pay all authorized obligations of this Society by vouchers. He may authorize the Executive Director to pay authorized obligations on his behalf. He shall keep a detailed account of all receipts and disbursements, and shall make an annual report to the House concerning the financial transactions of this Society for the preceding fiscal year, the funds of this Society in his care and his actions as Treasurer. He shall subject his accounts to such examinations as this House or the Council may order. He shall establish a revolving fund in an amount approved by the Council for routine expenses of the Executive office, which fund shall be set aside in a separate banking institution and be subject to check by the Executive Director with the understanding that disbursements therefrom shall be satisfactorily accounted by the Executive Director to the Treasurer before replenishment is made.

7.9 Executive Director

The Executive Director shall perform the duties

usual to such office except those specifically imposed by this Constitution and By-Laws upon the officers, councilors, committees, commissions, and other representatives of this Society.

He shall be under the employ of the Council, or its representative committee, and in case of his death, resignation or removal, the Council, or its representative committee, shall have the power to fill the vacancy. He shall employ such assistants as the House, the Council, or their representative committees may direct.

The amount of his salary shall be fixed by the Council or its representative committee, with approval of the House of Delegates. He shall be allowed traveling expenses to the extent approved by the Council. He shall use the revolving fund with due regard for efficiency and good business judgment in furtherance of the work entrusted to his care.

He shall be bonded at the expense of this Society in such amount as the Council may require.

He shall:

7.91 Account for, and promptly turn over to the Treasurer all funds of this Society which come into his hands.

7.92 Receive all bills against this Society.

7.93 Investigate their fairness and correctness.

7.94 Prepare vouchers covering the same.

7.95 Forward them, together with proper payment, to the Treasurer, for payment as provided in these By-Laws; or pay them with prior authorization from the Treasurer.

7.96 Keep an account with the component societies of the amount of their assessments, collect the same and promptly turn over the proceeds to the Treasurer.

7.97 Make an annual report of his activities to the House, and shall make such reports as the Council, or its authorized committees may require.

7.98 Within thirty (30) days preceding each annual session, submit his financial books and records to a certified accountant approved by the Council, whose report thereon shall accompany his annual report.

7.99 With the advice of all interested officers, prepare and submit annually to the House a tentative budget of this Society for the ensuing fiscal year, together with the recommendations of the Council, or its authorized finance committee, thereon.

7.910 Subject to instruction by the House, the Council, or the President, he shall act as general administrative officer and business manager of this Society. He shall refer to the proper officials all administrative questions as properly come within their jurisdiction.

7.911 Attend the annual sessions, the meetings of the House, the Council, as many of the committee meetings as possible, and shall keep the minutes of their proceedings.

7.912 Undertake secretarial functions for all officers, councilors, committees and commissions of this Society, and shall assist wherever possible in the performance of their duties.

7.913 With the cooperation of the secretaries of the component societies, he shall keep a record of all legally licensed doctors of medicine in this state, together with such information as is available about each. He shall transmit to the American Medical Association all copies of records that may be desired by that association, together with such other information as may be of value.

7.914 Endeavor to visit component societies when his duties will permit, or when an emergency requires personal attention, and shall keep the officers of the component societies informed about the activities of this Society and of the medical profession in general by the issuance of bulletins.

7.915 Supply the component societies with necessary forms and blanks for conducting their official business with this Society.

7.916 Inform the Society upon all pending or enacted legislation and upon activities of governmental offices and agencies affecting the medical profession and public health.

7.917 Secure, upon invitation, medical speakers to address lay organizations on subjects which are in accord with the aims and ideals of this Society. When requested, he shall assist the component societies in securing speakers and in preparing programs.

7.918 Notify all members of meetings, officers of their election, and committees of their appointment and duties.

7.919 Upon authorization by the Committee on Arrangements, he shall prepare and issue an official program for each annual session.

7.920 Provide for the registration of members and delegates at each annual session.

7.921 Be the custodian of the general papers and records of this Society except as properly belong in the custody of other officials.

7.922 Conduct the official correspondence of this Society, and shall sign all authorized communications.

7.923 Aid the councilors in organizing and improving the component and district societies, and in the extension of the usefulness and influence of this Society.

7.924 Act as business manager of KANSAS MEDICINE under supervision of the Editorial Board, and in a similar capacity to the extent authorized for other publications of this Society.

7.925 Perform any additional duties as may be required by the House, the Council, their committees or the President.

8.0 THE COUNCIL

8.1 Composition

8.11 Members of the Council are the President, President Elect, First Vice President, Second Vice President, Secretary, Treasurer, and Speaker and Vice Speaker of the House, Delegates and Alternate Delegates to the American Medical Association, and a councilor from each Council District. Each councilor and an alternate are to be elected by members of the component societies of the district prior to the convening of the House of Delegates; excepted, that the councilor or his alternate may be elected by a caucus of the delegates if the members have not done so by the date the House of Delegates convenes. The elected alternate replaces an active member in his absence.

8.12 Associate membership of the Council includes alternate councilors and one (1) representative each from the University of Kansas School of Medicine, the Kansas State Board of Health, the Kansas State Board of Healing Arts, and one (1) representative each from recognized specialty organizations. Associate members may attend plenary sessions of the Council but shall not be entitled to vote.

8.13 The Executive Director of the Society attends all sessions of the Council as an administrative advisor.

8.14 Advisory members of the Council are the Editor of KANSAS MEDICINE, chairmen of the Society commissions, and past presidents. They may attend plenary sessions of the Council, but are not entitled to vote.

8.15 The Executive Committee of the Council shall be composed of the President, the President Elect, the Immediate Past President, the First Vice President, the Second Vice President, the Secretary, the Treasurer, the Delegates to the AMA, the Speaker and Vice Speaker of the House of Delegates. The President of the Kansas Foundation for Medical Care shall be an ex-officio, non-voting member. The committee shall meet regularly and at least six (6) times during each year at the call of the President, and shall have authority to act in the interim between meetings of the Council upon all matters which would ordinarily require approval by the Council, which do not properly necessitate a special meeting of the Council and which have not been delegated elsewhere by these By-Laws.

8.2 Meetings

8.21 The Council meets at the conclusion of each annual session of the House of Delegates and at the call of the President during the year. A meeting is convened upon petition of five (5) active members of the Council.

8.22 Business may be transacted when a quorum is present. A majority of the active members is a quorum.

8.23 Adequate notice must be given the members by the Executive Director of the time and place of the meeting.

8.3 Duties

8.31 Between annual or special sessions of the House of Delegates, the Council or the Executive Committee of the Council will transact business on behalf of the Society. Council or Executive Committee action may not conflict with former action of the House of Delegates. Transactions of the Council otherwise have the same authority as those of the House of Delegates except they cannot bind the Society beyond its next annual session.

8.32 The Council is authorized to issue or revoke charters to component societies in the name of the Society. The council for the district of origin presents the application for charter to the Council. The application must contain the following information:

8.321 The geographical area to be included in the proposed component society.

8.322 Certification by the presiding officer of each component society within the area of the new society that his members have voted to relinquish the charter in effect.

8.323 A quarantee that all members affected will retain initial membership in the new society, but be subject to its by-laws subsequently.

8.324 The name of the new society; all to be attested by the signatures of the elected officers.

8.33 The Council shall supervise the publication of KANSAS MEDICINE. It appoints an editorial board of five (5) members, one of whom is named Editor (See 10.0).

8.34 The Council is responsible for the funds and expenditures of the Society. The Treasurer submits to it a budget of estimated expenses for the coming year. Appropriation of money for special purposes not previously budgeted must be authorized by the Council.

8.35 The Council sets the amount of dues for the coming year, directing the Executive Director to inform component societies no later than October 31.

8.36 The Council may impeach elected officers and councilors.

8.37 The Council is responsible for the determination, five (5) years in advance, of the time and place of the annual session of the Society.

8.38 The Council employs and supervises the activities of the Executive Director.

8.39 The President of the Society presides over the Council. In his absence the First Vice President will preside.

8.310 The Council may create committees from its membership to act between Council meetings. Special committees may include additional members of the Society who are not Council members. When the Society is invited to send a representative, or committee for service outside its own jurisdiction, the appointment(s) is made by the Council except in emergency when the Executive Committee may appoint.

8.311 All money of the Society is paid to the Treasurer who is accountable for it. The Council may inspect or audit the accounts of the Treasurer at any time, but at least annually; it may review or audit the expenditure of any officer, board or committee, and insure annual reports to the House of Delegates on all expenditures of the Society

8.312 If the office of Secretary or Treasurer is vacated, the Council appoints a successor for the unexpired term. To protect the new Treasurer, an audit is conducted at once. If a councilor position is vacated, the corresponding alternate sits as councilor until the annual session. Then a councilor is elected as provided above to complete the three (3) year term. The alternate so seated becomes a voting member of the Council. If the incomplete term is for less than two (2) years, the elected councilor is eligible for two (2) more terms.

8.313 A summary of Council activities and reports to it between sessions of the House of Delegates is submitted to the House at each annual meeting.

8.4 Council Districts

Council Districts are comprised as follows:

8.41 *District #1:* Atchison, Brown, Doniphan, Jackson, Jefferson, Leavenworth, Marshall, Nemaha, and Washington Counties.

8.42 *District #2:* Wyandotte County.

8.43 *District #3:* Johnson County.

8.44 *District #4:* Allen, Bourbon, Cherokee, Crawford, Labette, Montgomery, Neosho, Wilson and Woodson Counties.

8.45 *District #5:* Clay, Geary, Pottawatomie, and Riley Counties.

8.46 *District #6:* Shawnee County.

8.47 *District #7:* Chase, Coffey, Lyon, Morris, Osage and Wabaunsee Counties.

8.48 *District #8:* Butler, Cowley and Greenwood Counties.

8.49 *District #9:* Cloud, Dickinson, Jewell, Mitchell, Ottawa, Republic and Saline Counties.

8.410 *District #10:* Harvey, McPherson, Marion, Reno and Rice Counties.

8.411 *District #11:* Sedgwick County.

8.412 *District #12:* Barber, Harper, Kingman, Pratt and Sumner Counties.

8.413 *District #13:* Ellis, Ellsworth, Graham, Lincoln, Ness, Osborne, Phillips, Rooks, Rush, Russell, Smith and Trego Counties.

8.414 *District #14:* Barton, Edwards, Pawnee and Stafford Counties.

8.415 *District #15:* Clark, Comanche, Ford, Gray, Hodgeman, Kiowa, Meade and Seward Counties.

8.416 *District #16:* Cheyenne, Decatur, Gove, Logan, Norton, Rawlins, Sheridan, Sherman, Thomas and Wallace Counties.

8.417 *District #17:* Finney, Grant, Greeley, Hamilton, Haskell, Kearney, Lane, Morton, Scott, Stanton, Stevens and Wichita Counties.

8.418 *District #18:* Anderson, Douglas, Franklin, Linn and Miami Counties.

8.419 *District #19:* Allen, Chautauqua, Elk, Montgomery, Neosho, Wilson and Woodson Counties.

8.5 Notification of Councilor Election

The Executive Director will notify all component societies in a given Council district three (3) months prior to the annual session at which its councilor term ends. A poll may be held in the district before the annual session to select the new councilor whose official election is held as provided above.

8.6 Councilor Term of Office

Each councilor is elected for three (3) years. He may serve two (2) successive terms except as limited above (8.313). On one year, terms begin for councilors in Districts 1, 3, 5, 8, 9 and 17; the next year in Districts 2, 4, 11, 13, 14, 15 and 19; the third year in Districts 6, 7, 10, 12, 16 and 18.

8.7 Duties of the Councilor

The councilor represents the members of his district in the government of the Society. He is expected to know their needs and represent them fairly. Conversely, he represents the Society to the members of his district, giving rise to some of these duties by which he is bound but not limited:

8.71 He must afford societies within his district complete understanding of Society policy and activities.

8.72 He must visit each component society in his district at least once annually.

8.73 He must function as censor and peacemaker in his district.

8.74 He must aid in improving the organization of the societies in his district for their own efficiency and to augment the proper function of this Society.

8.75 He will call a district meeting at the request of the President.

8.76 He is expected to attend meetings of the Council. If he cannot be present, he must notify his alternate who will sit in the Council for him and exercise the vote of his district. His failure to notify his alternate after two (2) consecutive absences will represent resignation and the component societies in the district will select his successor to fill the unexpired term of his appointment.

8.77 He is obliged to teach his alternate the duties of councilor, to acquaint the alternate with Council policies and procedures, and to keep him informed of current Society transactions.

8.78 He serves as a voting member of the House of Delegates during his Council tenure (See 5.24).

9.0 COMMITTEES AND COMMISSIONS

Commissions and Committees are appointed by the President for a one-year term. The Chairman, size and membership of such commissions and committees shall be designated by the President. Commissions and Committees may introduce resolutions for consideration by the House of Delegates.

9.1 Judicial Committee

There shall be a Judicial Committee representing different specialties. One member of the committee shall be a physician representing the Kansas State Board of Healing Arts. The President shall appoint the committee subject to approval by the Council. The majority of the Judicial Committee shall constitute a quorum and the affirmative vote of a majority of those members present shall constitute the action of the Judicial Committee.

9.11 The Committee shall invite as a temporary, ex-officio member the councilor from whose district a complaint or possible cause of action shall have been submitted. In the event that the councilor is the subject of the complaint or cause of action, the alternate councilor shall sit in his place.

9.12 In the event that any member of the Committee is the subject of the complaint or cause of action, he shall be excluded during the Committee's deliberations and action on such complaint and from Committee membership, but shall otherwise retain the same rights and privileges as any other member of this Society.

9.13 The Judicial Committee is charged with the responsibility of reviewing and acting on grievances or matters of ethics involving a member of this Society. The committee will conduct such inquiries and investigations as are needed to render timely decisions on matters referred to it. Decisions of the committee may be appealed to the Council. The decision of the Council on such appeals is final and subject to no higher appeal within this Society. The committee may utilize such consultants and advisory committees as it may require.

9.14 The Judicial Committee shall receive written complaints from any person, whether or not he or she is a physician, a member of this Society, a patient of a physician, or any other person, lay or professional.

9.15 After investigation of, impartial hearing of, and deliberation upon a complaint, the Judicial Committee by majority vote, may:

9.151 Consider the case closed.

9.152 Recommend settlement.

9.153 Express its advice to a member of this Society on any matter pertaining to his or her professional conduct.

9.154 Recommend to the Council of the Society:

9.1541 That it take action to expel, suspend or reprimand a member.

9.1542 Submit proposed charges to an appropriate state or federal law enforcement agency.

9.1543 Submit the case and findings to the Kansas State Board of Healing Arts.

9.16 Upon reaching a decision, the Judicial Committee chairman shall transmit to the Council

and the Board of Healing Arts a written statement and explanation of the final decision as soon as possible after the committee has completed the investigation of the case and has arrived at its decision.

9.17 The Judicial Committee shall keep a complete record of all complaints, answers, findings and final disposition of its decisions and disposal of complaints, and shall prepare an annual report to the Kansas Medical Society.

9.18 The Judicial Committee shall not at any time exceed or take by assumption any authority other than that granted by this Constitution and By-Laws.

9.2 Committee on State Meeting Format

The Committee on State Meeting Format is comprised of the most recent general chairman of the annual session from each city where sessions are held. The term of office ends when a new general chairman is appointed by the respective component society. The President Elect is chairman of this committee which meets not later than sixty (60) days after each annual session in the host city for the next session. The meeting is held to review with the local planning committee plans for the coming session. The committee further recommends a general meeting plan to the host society selected for two (2) years later.

9.3 Policy Statements

Public statements of policy by commissions or committees have only the force of recommendations, becoming Society policy after approval of the House of Delegates or the Council.

9.4 Expenditures

Expenditures by commissions or committees must have prior approval of the House of Delegates or the Council to be binding on the Society. No contract or monetary obligation shall be incurred in the name of the Kansas Medical Society by any member, employee or agent until he is authorized by the House of Delegates, the Council or the Executive Committee. Authorization cannot extend beyond the next annual session.

10.0 THE EDITORIAL BOARD

10.1 Composition and Appointment

The Editorial Board is comprised of the society members, appointed by the Council. When a vacancy occurs it is to be filled for the unexpired term at the next meeting of the Council.

10.2 Duties of the Chairman

10.21 To direct the operation of the Board and be the Editor of KANSAS MEDICINE.

10.22 To make reports to the House and Council of the activities of the Board.

10.3 Duties of the Board

10.31 To perform the functions necessary to the publication of KANSAS MEDICINE and other publications considered necessary by the House of Delegates or the Council.

10.32 The Board may appoint associate editors from any Council districts for particular functions in fulfillment of its duties.

10.33 The Board with its associate editors will meet each year at the annual session and at the call of the chairman.

10.4 Financial Regulations

10.41 The Board is enjoined to maintain KANSAS MEDICINE within budgetary limits established by the Council.

10.42 Expenditures authorized by the Board are to be paid by the Kansas Medical Society upon authorization by the Business Manager of KANSAS MEDICINE.

10.44 Surplus funds accruing to KANSAS MEDICINE or other publications at the end of the fiscal year are deposited to a reserve account within limits established by the House of Delegates or the Council. Surplus funds beyond that limit will revert to the general fund of the Society.

11.0 COMPONENT SOCIETIES

11.1 Definition

Component societies are groups of physicians organized in the State of Kansas, adopting principles of organization in accordance with these By-Laws and receiving a charter from this Society.

11.2 Charter Requirements

11.21 Each county shall be included among the component societies in this state, but only one (1) component society may be chartered in a county.

11.22 New component societies will not be chartered with fewer than ten (10) members.

11.23 Physicians in counties with too few physicians for a successful organization may affiliate with those of adjoining counties to form a multicounty component society.

11.24 Charters are granted to component societies upon action of the Council as provided above (8.32).

11.25 Following Council recommendation, the House of Delegates may revoke the charter of a component society whose actions conflict with these By-Laws.

11.26 If the active membership of a component society falls below four (4) in number, its charter shall be revoked and the members reassigned by the Council to one of the following alternatives:

11.261 Attach the entire membership to the nearest component society.

11.262 Attach the entire membership to any adjacent medical society by unanimous request of the members.

11.263 Attach the members separately to adjacent medical societies for reasonable cause.

11.3 General Regulations

Component societies may set rules for membership qualification, organization and transaction of business except as specifically limited in these By-Laws.

11.4 Regulations For Membership

11.41 Since membership in this Society is dependent on that of the component society except as noted in Section 11.411, any reputable and ethical physician with the degree of Doctor of Medicine or Osteopathy, or their equivalent, from an accredited medical or osteopathic school, fully licensed to practice medicine and surgery by the Kansas State Board of Healing Arts, and the majority of his professional work being conducted in the state, shall have the privilege of applying for component society membership. Also eligible for membership shall be students attending accredited medical schools in Kansas.

11.411 Medical students and resident physicians shall be eligible for membership in the Kansas Medical Society by applying through the component medical society or by applying directly to the Student or Resident Section.

11.42 A physician may not hold active membership in two component societies.

11.43 No physician may be an active member of a component society without becoming a member of the Kansas Medical Society.

11.44 A physician living in one county but conducting his practice in another is eligible for membership in the county where the majority of his work is performed. He may maintain active membership for reason of convenience in the county of his residence only with the permission of the society within whose jurisdiction he practices.

11.5 Movement Within the State

A member of any component society, upon establishing the majority of his practice in the area of another component society, may retain his original membership only with the permission of the society into whose jurisdiction he moves.

11.6 Transfer of Membership

A member desiring to transfer membership from one component society to another applies to the new society in the same manner as an original applicant. His application is accompanied with an appropriate recommendation and a report of his standing in the previous society, attested by the president. When the application has been acted upon, the secretary will notify the applicant at once of the society's decision. The secretary of the previous society is also notified since acceptance by the new society requires that he be dropped from the roll of previous membership. Rejection by the new society does not affect membership status in the previous society.

11.7 The Annual Report

The secretary of each component society will maintain a roster of its membership and of non-affiliated registered doctors of medicine or osteopathy within its boundaries. The roster must include for each member his address, medical or osteopathic school and date of graduation, date of license to practice in Kansas, and the dates of past changes in membership status. Only the names and addresses of non-members need be recorded.

On or before the first day of February, the secretary shall forward a current roster to the Executive Office, including notations of death or change of membership status among members and, as far as possible, among non-members.

11.8 Dues and Assessments

11.81 All dues owed the Society should be remitted before the first of February of each year unless permission for a delay is secured from the President. The remittance may not be delayed beyond the first of April of the same year. The number of delegates of all component societies shall be determined on the basis of information regarding membership available to the state society office as of March 15 of each year; and a list of delegates and alternates shall be submitted to the Executive Director no later than March 20 of each year for the purpose of publishing the names in the program of the annual meeting in May. Assessments are due under the same rule unless special provisions are set by the Council.

11.811 A member delinquent in the payment of his dues on April 1 of that dues-paying year shall be suspended.

11.8111 A member remaining in arrears as of July 1 of that dues paying year shall be removed from the membership roles.

11.82 Individual checks of funds for dues to the American Medical Association are transmitted from the treasurer of the component society through the Executive Office to the proper destination.

11.83 A component society failing to pay its dues or assessments according to these By-Laws is suspended from membership in the Society until the requirements are met or until written certification of the suspension of members in arrears is received by the Executive Office.

11.831 Any member dropped from the membership rolls for delinquent dues shall be readmitted only after applying as a new member.

11.84 A component society suspended from membership in violation of this section is not eligible collectively or individually to participate in the proceedings of this Society nor seats in the House of Delegates until the deficiency has been corrected.

11.85 Punitive action will not be instituted against a component society certifying that members in arrears have sufficient cause from illness, leave of absence, or otherwise, which prevents the practice of their profession. If the component society finds cause to waive the local dues of a delinquent member, a written account should be sent to the Executive Office. The Council will then determine whether the waiver should be properly extended to the dues of the Society. The secretary of the concerned component society will be notified of the Council decision by its district councilor.

12.0 RULES OF ORDER

Deliberations of this Society and its subsidiary Council, sections, commissions and committees shall be governed by these By-Laws, and when not otherwise specified by the provisions of Sturges' Standard Code of Parliamentary Procedure.

"The Rules of Order and By-Laws of this Society may be suspended at any time by a vote of two-thirds of those delegates present."

13.0 OFFICIAL STATEMENTS

Memorials, resolutions or opinions of any character which conflict with policies of the House of Delegates shall not be issued in the name of the Kansas Medical Society. No obligation, oral or written, shall be incurred in the name of the Kansas Medical Society by any member, employee or agent unless the same has been previously authorized by vote of the House of Delegates, or the Council, or the Executive Committee and no such authority shall be extended beyond the next annual meeting of the House of Delegates.

14.0 MEDICAL ETHICS

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members.

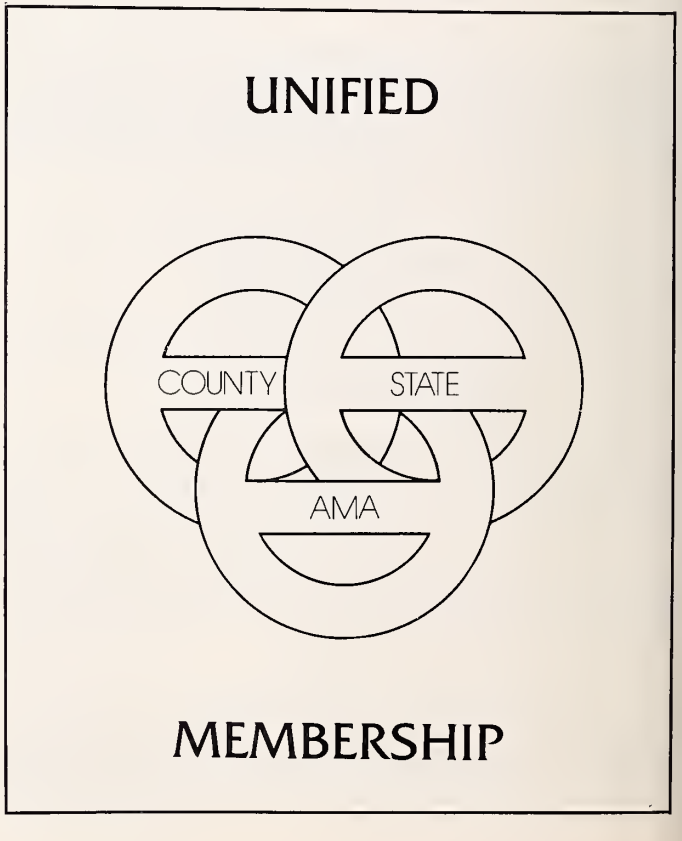
15.0 AMENDMENTS

These By-Laws may be amended by a two-thirds majority of the House of Delegates present provided such amendment has been considered by a reference committee.

RESOLUTION OF ADOPTION

Be it hereby resolved that this revised Constitution and By-Laws shall be in full force and effect at the close of the meeting of its adoption and shall supersede all prior Constitutions, By-Laws and Amendments.

Likewise, officers, councilors, board and committee members holding offices for definite terms under the previous Constitution and By-Laws shall serve until expiration of term for which elected and until their successors, as provided by this revised Constitution and By-Laws, are duly elected, qualified and installed.



PRESIDENT'S MESSAGE



I just read an article in *Medical Economics* that stresses the interaction between over-the-counter (OTC) drugs and prescription medications. It was less a medical article than a legal one, relating to the physician's liability when patients take OTC drugs that react against their regularly prescribed medications. It ended by admonishing the physician to ask about OTC drugs because "that is your responsibility."

There are numerous cases where a physician has been held liable for a patient's reaction to a prescribed drug, particularly if he/she failed to check the patient's records for allergies, or forgot to ask the patient about reactions.

A recent issue of *Malpractice Journal* reported the case of a physician who was found guilty of not providing adequate care even though he had twice advised the patient that surgery was needed. It was ruled that the physician was not emphatic enough and did not sufficiently outline the consequences if surgery was not performed.

How did the medical profession ever get into this situation of being held legally accountable for patients' actions or inactions? If patients are adult and competent, why is it the physician's responsibility to ask about OTC drugs? Why isn't it the patients' obligation to supply this information? Why is it not the patients' duty to state they have allergies when physicians prescribe for them? Physicians have no legal right to force their decisions on patients; all they can do is advise. If patients refuse to accept that advice, why are they not responsible for their decisions?

Some would reply that a patient doesn't have the knowledge and sophistication to assume these responsibilities. But the argument totally reverses itself when patients sue surgeons for lack of informed consent. Here they often say that had they been told of all options, they would have been wiser than the surgeons in choosing appropriate treatments. How schizophrenic!

The time has come, once again, when people should be willing to take responsibility for their own actions and we should insist on it.

I hope all of you have a safe, happy holiday season and that among your resolutions will be the resolve to close ranks with your fellow physicians and work together to safeguard our professional integrity.

E. E. Leonard, M.D.

President

EDITORIAL COMMENT

Public Address System

THE RECONSTRUCTIVE surgery that the face and form of medical service have undergone in recent times has extended even to those sacrosanct areas, clinical and laboratory research. Increasingly, the public has appeared at the patient's bedside or laboratory bench to observe with both fascination and criticism.

This has been exemplified by the recent (as of this writing) example of the media-orchestrated announcement by a French team of the dramatic results in the treatment of AIDS. The idea of the press conference itself is now old hat. What warrants comment is that the study was based on *two* cases.

The treatment itself, apparently the essence of the "hair of the dog" principle, was unusual enough to cause mixed reactions from other knowledgeable but bemused investigators — from frank scorn on traditional grounds to hedgingly cautious comments permitting subsequent support if merit of the idea becomes certain, or condemnation if the odds catch up in subsequent experience.

But this is only a narrow view of a larger picture, although it derives from what must be one of the most publicized pressures ever to develop on the medical scene. Any physician knows that patient and physician no longer have the leading roles in the scene. Third — or fourth — parties have become a fixture. The ubiquitous media are now bedside companions as they vie for scoops for the morning edition or the six o'clock news. And they provide that which would have been unthinkable not too long ago — a forum for physicians to claim publicly glowing results of professional success.

The situation points up the fact that the profession has adopted a new attitude toward itself and its work. It is not just a case of physician self-promotion being tolerated as a form of public education. Ethical restrictions have moved from prohibition of personal aggrandizement to an uncomfortable reexamination to capitulation and professional acceptance (save only a few holdouts once looked upon as fearless defenders of noble principles and now as stubborn malcontents).

The reality is that it comes down to power, and power these days (perhaps all those previous days) is measured in money. The developers and backers of medical research — foundations, health organizations of various disease interest, hospitals, agencies of government — must compete for funds by publicizing successes — activities at least. In every instance, this means that they must turn to one or another of the media forms to report and promote their activities and attract continuing and growing financial support. State medical institutions must assure legislators of their great value — relative to other places the money might go. The result has been that the public relations offices of all these entities have become as much or more important to medical progress as the vision and brains inside the walls.

So we have an interesting spectacle. The public, fed on a steady diet of various medical terrors, demands immediate correction of such problems (overlooking the age-old admonition that it still takes nine months to have a baby). It demands the universal solution: *put more money into it*. Entertainers of various stripe put on widely publicized benefits, the income from which may or may not get where the supporters expect — but the principals are assured of massive publicity.

We have the physician team in one area reporting dramatic accomplishments (approaching *National Enquirer* luridness) and the next news report gives a scoffing rebuttal by other teams in other locations. The public arena has become the laboratory.

And we have international press conferences to report success on the basis of experience with *two* patients. — *D.E.G.*

MEDICINA ET LEX

Consent Issues

WAYNE T. STRATTON, J.D.,* *Topeka*

THE TYPICAL RELATIONSHIP between a physician and a patient is contractual. The patient knowingly seeks treatment which the physician provides. The need for consent arises because the law recognizes that the patient is an autonomous individual who is free to authorize or refuse the administration of medical treatment. Although treatment without the patient's consent legally constitutes a battery, Kansas courts prefer to view lack of consent matters as negligence. These cases are hard to prove without the claimant producing expert evidence that the physician acted unreasonably.

There are situations where the patient is not able to consent to treatment because the patient is a minor, incapacitated, or too ill to consent. The patient may even be unconscious or unable to communicate. These special situations pose an ethical and a practical dilemma for physicians. Should physicians risk lawsuits based upon lack of consent, or should they render needed assistance? By passing several statutes, the Kansas legislature has answered this question in favor of giving the physician freedom to treat.

The law recognizes that special circumstances exist where the patient may not be able to consent because of his/her physical condition. The doctrine of implied consent is "judge-made" law. If a patient is injured, unconscious or unable to consent to medical procedures, and the patient's injuries require prompt treatment, a formal consent is unnecessary. This rule applies to minors and incapacitated individuals, as well as to competent adults.



The need for parental consent when treating a minor poses particular problems for physicians. The agreement to render medical care is a contract that requires consent of each contracting party. Minors are not legally bound by their contracts; therefore a minor's consent to treatment will not ordinarily be sufficient to eliminate a legal battery. Recognizing the harshness of holding a physician liable for the non-negligent medical treatment of minors, the courts and legislature have established exceptions to this rule.

Emergencies are the primary exception. In emergencies or when the parents are so remote as to make consent impractical in time to accomplish the proper results, the physician may treat a minor without parental approval. Under Kansas statutes, a minor who is 16 years old may consent for him/herself if no parent is immediately available. The emergency exception has been expanded and modified. Courts consider the age and maturity of the minor, the perceived seriousness of the condition treated, and the difficulty of locating the child's parents. The reasonableness of medical intervention is the point upon which many of the cases are decided.

The Kansas legislature has created exceptions for instances where the necessity of parental consent

(Continued on page 372)

*KMS Legal Counsel

Editor's Note: This is the third in a series of regular columns concerning current subjects of legal interest to physicians. For the sake of brevity and clarity, citations and footnotes will be omitted.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE *or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka KS 66603; 913-233-0593.*

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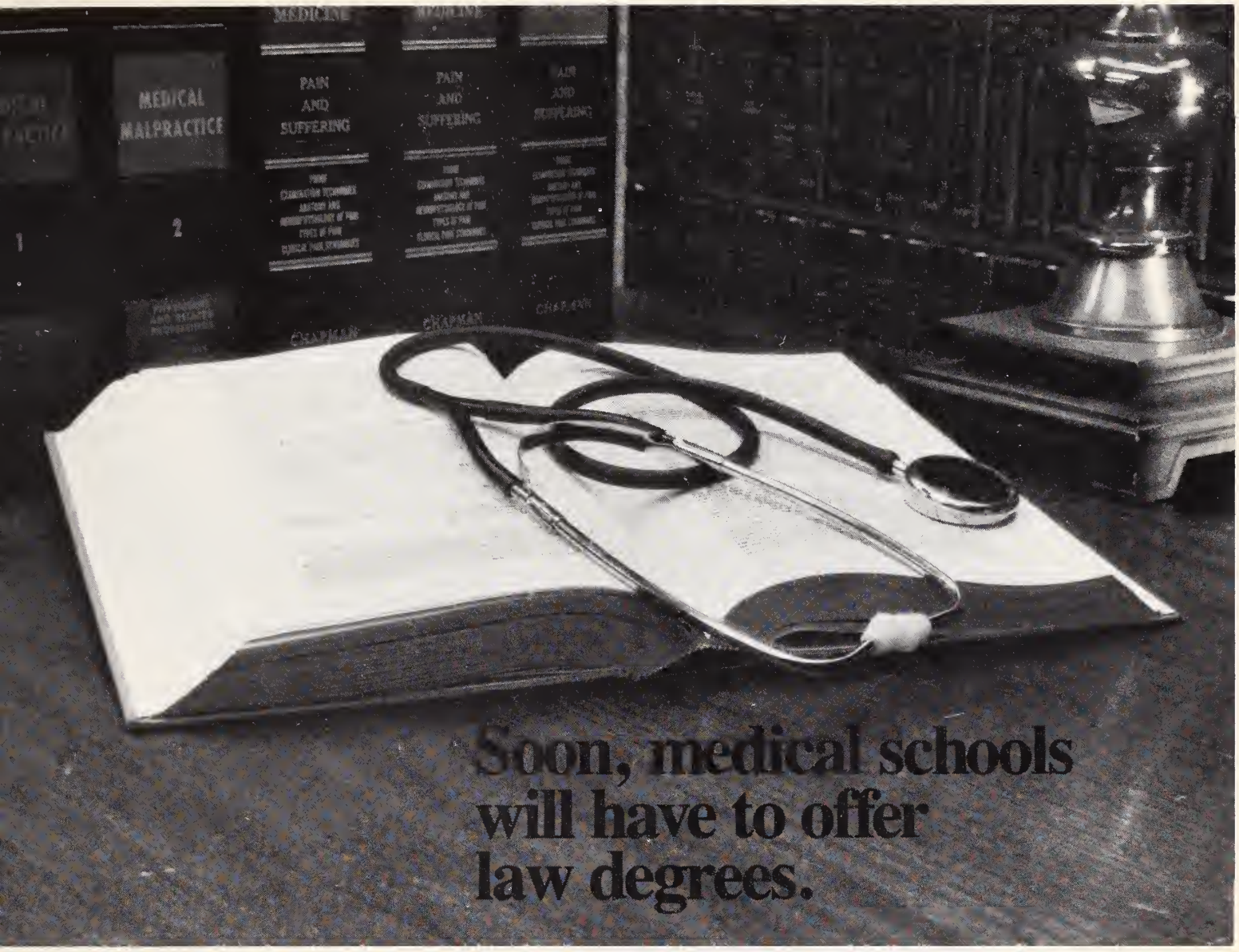
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Consent Issues

(Continued from page 367)

would invade the child's privacy and would discourage the child from seeking medical assistance when treatment is socially desirable. Thus, any person under the age of 18 years may consent to examination and treatment for venereal disease or for substance abuse. An unmarried minor may consent to care and treatment related to pregnancy when a parent is unavailable. Parental consent is also deemed unnecessary in order to perform an examination on a child who is the victim of a sexual offense.

Emancipation is another exception to the parental consent rule. Emancipation reflects a high degree of independence. Marriage, economic independence, separate living arrangements, military service, or abandonment by the parents are indicia of emancipation. The emancipated minor is legally free from parental maintenance, custody, care and control, and may therefore be treated without parental consent. By statute in Kansas, a minor who is a parent may give valid consent to treatment for themselves and their children.

Good Samaritan laws have been enacted in 48 states, including Kansas, and provide protection for emergency treatment that is rendered with or without the parent's consent. Of course, if the patient is conscious and competent and refuses treatment, the physician should not render assistance. Good Samaritan laws simply prevent liability for civil damages when a physician treats an injured person in an emergency situation. The Kansas law is broader than Good Samaritan laws enacted in most states and affords the physician a greater ability to render emergency aid.

Unless the physician acts in such a manner as to willfully harm the patient, or unless the physician is extremely careless in his/her treatment, Kansas physicians can render aid at an accident scene or scene of an emergency without fear of later liability. Such medical assistance may be given to minors as well as to adults. Under the Kansas Good Samaritan law, a physician may treat a minor who is injured in a competitive sports event without parental consent; however, the physician may not receive compensation for this treatment.

While the statutory protections of the Good Samaritan Laws and Kansas Consent Laws may help physicians treat patients under emergency conditions or questionable circumstances with a greater sense of freedom, another fact may also put to rest a physician's lingering doubts on whether to treat a patient without prior consent in an emergency: There are no reported cases in Kansas where a physician has actually been sued for treating a patient in an emergency situation.

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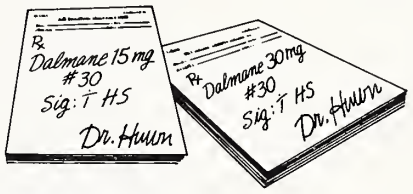
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